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DISABILITY AMENDMENTS OF 1982

HEARINGS

BEFORE THE

SUBCOMMITTEE ON SOCIAL SECURITY

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

SECOND SESSION

ON

H.R. 5700

TO AMEND TITLE II OF THE SOCIAL SECURITY ACT TO PROVIDE ADJUSTMENT BENEFITS, VOCATIONAL TRAINING, AND WAIVER OF OVERPAYMENTS FOR INDIVIDUALS TERMINATED FROM THE DISABILITY PROGRAM, TO STRENGTHEN THE RECONSIDERATION PROCESS BY PROVIDING FOR THE EARLIER INTRODUCTION OF EVIDENCE OF RECORD, TO PROVIDE FOR MORE UNIFORMITY IN DECISIONMAKING AT ALL LEVELS OF ADJUDICATION, AND FOR OTHER PURPOSES

MARCH 16 AND 17, 1982

Serial 97–54

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DISABILITY AMENDMENTS OF 1982

TUESDAY, MARCH 16, 1982

House of Representatives,
Committee on Ways and Means,
Subcommittee on Social Security,
Washington, D.C.

The subcommittee met at 9:40 a.m., pursuant to notice, in room B-318, Rayburn House Office Building, Hon. J. J. Pickle (chairman of the subcommittee) presiding.

[The press release follows:]

[Press Release of Wednesday, Mar. 3, 1982]

Hon. J. J. Pickle (D-Texas), Chairman, Subcommittee on Social Security of the Committee on Ways and Means, Announces Hearings on H.R. 5700, the "Disability Amendments of 1982"

The Honorable J. J. Pickle, (D-Texas), Chairman of the Subcommittee on Social Security of the Committee on Ways and Means, U.S. House of Representatives, announced today that his Subcommittee would hold a hearing on H.R. 5700, the "Disability Amendments of 1982," a bill to amend title II of the Social Security Act to provide adjustment benefits, vocational training, and waiver of overpayments for individuals terminated from the disability program, to strengthen the reconsideration process by providing for the earlier introduction of evidence of record, to provide for more uniformity in decision-making at all levels of adjudication, and for other purposes. This legislation was introduced today, and a detailed description of its provisions are inserted in today's Congressional Record. Other legislation on the disability insurance program will be considered at this time also. The hearings will be held on Tuesday and Wednesday, March 16, and 17, 1982, in Room B-318 of the Rayburn House Office Building, beginning at 10 a.m. each day.

The following is a capsule summary of H.R. 5700:

PROVISIONS TO PROVIDE ADJUSTMENTS IN DISABILITY TERMINATION (CDI) PROCESS

Permanent changes

Allow benefits to continue until reconsideration (similar to SSI program), subject to overpayment if appeal is lost.

Temporary changes (apply only through calendar year 1984)

Provide vocational rehabilitation services for medically terminated CDIs. Waive overpayments for period before notice in medically terminated cases (not in cases, for instance, where earnings are found). Allow "adjustment benefits" for four months after month of termination in cases of medical termination for individuals on rolls at least 36 months.

PROVISIONS TO INCREASE ROLE OF RECONSIDERATION PROCESS

Close record after reconsideration.

Lengthen appeal time to reconsideration level from 60 days to six months.

Provide face-to-face hearing at reconsideration (through Social Security if the State agency wishes) for medical termination cases only (effective in 18 months).

PROVISIONS TO PROVIDE MORE UNIFORMITY OF DECISION-MAKING

Own-motion review of ALJ allowances.

Precedent material uniform and applicable at all levels of adjudication.

Definition of pain.

Medical school courses and continuing education in disability determination and establishment of a permanent Advisory Council on Medical Aspects of Disability.

Social Security Court.

Elimination of court remand.

PROVISION TO PROVIDE MORE ACCOUNTABILITY IN CONSULTATIVE EXAMINATIONS

Payment of fees for consultative examinations through a single carrier.

PROVISION TO PROVIDE MORE RECENT ATTACHMENT TO WORK FORCE AS A REQUIREMENT FOR INSURED STATUS

Require participation in social security program for two out of last six years in addition to present requirement of five out of last ten years (20 out of 40 quarters).

MISCELLANEOUS PROVISIONS

Index SGA and trial work levels for increasing wage.

Deregulation of attorney's fees and exemption of social security claims from Equal Access to Justice Act.

Amendments relating to workmen's compensation.

Priority for social security cases in federal court.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony at the hearing should submit their request to be heard by telephone to Harriett Lawler, to be followed by a formal written request to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515, telephone (202)225-3627. The initial telephone request must be received by the Committee not later than the close of business, March 10, 1982. Notification to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

It is urged that persons and organizations having common position make every effort to designate one spokesman to represent them in order for the Subcommittee to hear as many points of view as possible. Time for oral presentation will be strictly limited, with the understanding that a more detailed statement can be submitted for the Subcommittee's review and for inclusion in the printed record of the hearings. This will afford more time for interrogation of the witnesses by the members of the Subcommittee. If it becomes necessary, the staff will group the witnesses into panels to expedite the hearings and will establish strict time limitations for each panelist.

The following is an outline of the procedure to be followed by organizations and individuals who may either want to appear and testify during this hearing or file a written statement for the printed record of the proceedings. All requests to be heard should contain the following information:

1. The name of the witness, his title, address, firm affiliation and/or organization he will represent (as well as a telephone number where he or his designated representative may be reached).
2. If appearing in an individual capacity, a list of any clients at whose request or in whose employ the witness appears.
3. A topical outline or summary of comments and recommendations.

The above information should also be incorporated in the prepared statement to be presented in person as well as those filed for the printed record. In order to assure the most productive use of the limited amount of time available to question hearing witnesses, witnesses scheduled to appear before the Subcommittee are required to submit 50 copies of their prepared statement to the full Committee office, Rm. 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENT IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the record of the hearing, five copies are required and may be submitted through the close of business, March 31, 1982, to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office before the hearing begins.

Chairman PICKLE. The Chair would ask the subcommittee to come to order. We will proceed.

Contrary to popular belief, the social security disability program is very healthy financially. The percentage of workers on the disability rolls is the lowest in the history of the program. State agencies charged with making the disability awards are tightly enforcing the definition of disability as contained in the Social Security Act.

Two years ago, this Congress passed significant legislation, Public Law 96-265, with the specific purpose of improving the administration of the disability program, and of providing greater work incentives to disabled beneficiaries. We find, however, that there are many things in the disability program that need our attention, and in some cases our immediate attention.

Many members have raised concern about the re-examination of individuals on the disability rolls which have resulted in the precipitous termination of benefits for workers who in some cases have been receiving disability benefits for several years. We must have a review of the rolls.

The program has come under criticism in the past because this was not being done. At the same time, until this process is settled down and becomes a regular part of the proceedings so that it does not come as such a surprise to the recipients, some adjustments and special allowances are in order.

In these hearings, we hope to explore several adjustments to help this process. We hope also to explore several proposals to change the administration's program. The committee is concerned about the imbalance between the State reconsideration and Federal administrative law judge levels of the appeals process, about the lack of uniformity in decisionmaking among the various appeals levels, about the lack of accountability in the use of volume medical examinations, and about other aspects of the administration of the program.

On March 3, Congressman Archer and I introduced H.R. 5700, to address these various concerns. We do not propose this or any other legislation as a final response, and we are open to all suggestions in this field.

I wish to serve notice that because of the shortness of the legislative session and the need to act quickly on some of these areas, we intend to move to markup on this legislation next week, at least regarding those portions of the bill on which there seems to be general agreement. While some proposals may require a longer study, many portions of this bill have already been before the committee or are not expected to be controversial, and we should move forward.

We have several witnesses this morning whom we are pleased to have with us. The first witness is the Commissioner of the Social Security Administration, Mr. Svahn, who has been very cooperative with this committee and very helpful and very concerned about the proposal that we have before us.

We are pleased, Commissoner Svahn, to receive your testimony at this point.

STATEMENT OF HON. JOHN A. SVAHN, COMMISSIONER OF THE SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY JAMES S. JEFFERS, ASSOCIATE COMMISSIONER FOR GOVERNMENTAL AFFAIRS; LOUIS B. HAYS, ASSOCIATE COMMISSIONER FOR HEARINGS AND APPEALS; AND RHODA GREENBERG, DIRECTOR, OFFICE OF DISABILITY PROGRAMS

Mr. Svahn. Thank you, Mr. Chairman.

Before I go into my statement, I would like to introduce the other witnesses here at the table with me.

Chairman Pickle. Please do so.

Mr. Svahn. On my left, Mr. James S. Jeffers, Associate Commissioner for Governmental Affairs, on my immediate left, Mr. Louis B. Hays, the Associate Commissioner for Hearings and Appeals, and on my right, Ms. Rhoda Greenberg, Director of the Office of Disability programs.

Chairman Pickle. We are glad to have all of you with us, Commissioner.

Mr. Svahn. I appreciate the opportunity to appear here today before your subcommittee to discuss the social security disability program and the bill you have introduced to improve the administration of the disability program.

As this committee knows better than anyone, there are serious problems in the disability program. Numerous GAO reports, surveys and reports by this committee, and internal SSA studies have documented deep-seated and long-standing problems in many areas of the disability program. Over the years, this committee has provided outstanding leadership in the effort to make an inherently difficult to administer program operate as efficiently and effectively and fairly as possible. The 1980 disability amendments, which this committee played a major role in developing, were an important step forward in improving the disability program.

As you know, Mr. Chairman, we are working with the National Commission on Social Security Reform to develop some long-term changes in the financing structure of social security, and we believe that they will be addressing the substantive areas of the disability insurance program in their final report.

In the meantime, we in Social Security have been moving aggressively to address problems in the disability program with changes that we can make under present law, primarily in administrative areas. Our objectives are simple. We need to insure that all those—and only those—claimants who are actually disabled will be found entitled to benefits, and those who are no longer disabled will be promptly removed from the disability rolls.

We need to process claims in a timely fashion so that claimants do not encounter undue delays in having their claims adjudicated, both at initial and appellate levels. We need to treat claimants in like circumstances uniformly throughout the country and at all levels of adjudication. And we need the medical evidence used in making disability decisions to be of high quality.

We have undertaken various administrative initiatives to help achieve these objectives, Mr. Chairman. We set up a group of personnel within the Social Security Administration, we included four State DDS administrators in that group, to look at some options that we can take or some choices that we can make administratively to make the 3-year period that we are engaged in, in this initial review under the CDI program, a smooth transition, much the same as some of the time limited facets of your bill.

Last week, we decided to use what I can only call a commonsense test in making determinations about when an individual had recovered from a disability. It makes little sense to decide that a person had medically recovered in the past and must repay us benefits, when the delay in our determination is the fault of the system rather than the individual, and I think you pointed that out, Mr. Chairman, in your floor statement.

In the instance where delay would appear to be a case of fraud, however, we will make a retroactive determination of medical recovery and prosecute to the full extent of the law. I think what that means, Mr. Chairman, is, we have made the administrative decision to in a sense implement one of the provisions in your bill. We have the authority to do that now, and we are doing so at present.

We are currently reexamining the status of all disability beneficiaries on the roll. I think that has prompted some of the provisions in your bill. We are expanding the use of Social Security rulings binding at all levels of adjudication to assure uniform application of adjudicatory standards throughout the Nation. I believe that that is also covered in your bill.

We have been doing sample reviews of initial denials on a preeffectuation basis as well as the approvals, and I have asked that we get some creative interpretation to allow us to do more in that area.

We implemented own-motion review of ALJ allowances on October 1, 1981. We are doing three disability appeals reform experiments, the so-called DARE experiments—I don't like the acronym, but there is not much I can do about it now—to test if there are ways in which the State DDS reconsideration process might be improved.

We are expanding the administrative law judge corps and support staff to reduce the backlog and speed up processing of the increased hearings' caseload. We are introducing innovative processing techniques in our hearing offices, improved training, and modern equipment designed to increase productivity by insuring efficient use of our resources.

Mr. Chairman, we agree that in addition to the administrative steps we are taking, some legislative changes are desirable. I believe we share a common perception of the nature of some of the problems we need to address, and many of the basic objectives to be achieved by needed changes. While we are not prepared at this point to take a position on each of the provisions of the bill or on the bill as a whole, I would like to say that I think H.R. 5700 is generally a constructive and helpful piece of legislation that we would like to work with you to perfect.

I will comment very briefly on some of the specific provisions in H.R. 5700. First, section 2 would allow a disability beneficiary that Social Security has determined had medically recovered to elect to have disability benefits continued up through the reconsideration stage of the appeal. A beneficiary who lost the appeal would be required to repay the benefits.

While we realize that termination of disability benefits often results in a difficult adjustment period for a beneficiary, this approach might encourage some frivolous appeals and add to our already large backlog of appeals which your bill is intended to reduce. Moreover, Social Security would probably not be able to recover a significant amount of the benefits paid, which would increase rather than decrease the debts owed to SSA.

Section 3 would provide for payment of 4 months of adjustment benefits to beneficiaries who are terminated for medical recovery after being on the benefit rolls for at least 3 years. Section 4 would provide that any disability benefits paid before the month the beneficiary was notified that benefits would terminate because of medical recovery would not be considered overpayments.

Both sections 3 and 4 would be in effect only through 1984. As I indicated, we are already taking action through regulations to achieve the objective of section 4 on a permanent basis, and both sections 3 and 4 would not apply if the termination of benefits had been delayed because the beneficiary had willfully neglected to report his or her medical condition. The willful neglect exception, Mr. Chairman, would complicate the administration of these provisions, because it would require extra development and an additional determination by SSA concerning an intent, and as the attorneys will tell us, determining intent is often difficult to do.

Section 5 contains several provisions to strengthen the reconsideration stage of appeal—closing the record after a reconsideration decision, lengthening the time in which a claimant can request reconsideration to 180 days, and requiring a face-to-face evidentiary hearing at the reconsideration level on terminations of disability benefits. A more meaningful reconsideration process would screen out many cases that now go to the hearing level, and would help reduce the heavy growing workload at that level. The need for further development at the hearing level would be eliminated.

Section 5 would also revoke the authority of Federal district courts to remand cases back to the Secretary for further consideration, which would further reduce workloads at the appeals level. We agree with the objective of reducing processing times for social security cases in Federal courts.

Section 6 would require Social Security to review 15 percent of all favorable disability determinations made by ALJ's in fiscal year 1982 and 35 percent thereafter. We do agree, Mr. Chairman, that a review of the ALJ decisions is desirable to improve accuracy of decisionmaking and have such a program in place. Since October 1, 1981 we have been reviewing about 7½ percent of all ALJ allowances, and by early April we will expand our review to 15 percent of allowances. We will expand this review in future years, as we gain experience and can determine what level is most appropriate. For this reason, we would prefer that the percentages of review not be specified in the law.

Generally speaking, fixed percentages should not be in the law because they can limit necessary administrative flexibility which we should have to achieve the best result.

Section 7 would provide that the same adjudicative standards would apply at all levels of adjudication, and that these standards would be the regulations, the social security rulings, and the adjudicative standards of part 4 of the Program Operations Manual System, which we refer to as the POMS.

We agree with the objective of this provision. I have already directed that we issue social security rulings that are binding on all levels of adjudication to incorporate the adjudicative standards of the POMS. Thus, a specific reference in social security law to the POMS does not seem necessary.

Section 8 would provide an explicit statement in the law of SSA's policy on the evaluation of pain in making disability determinations. This has been another troublesome area for the agency, because so many ALJ's and courts have not followed SSA's policy. Section 8 would make clear to all levels of adjudication the specific standards to be used.

Section 9 would require as a condition of eligibility for disability benefits that a person have worked in at least 2 of the 6 calendar years ending with and including the year the disability began, 8 quarters of coverage out of 24 calendar quarters. Work not covered under social security could be counted to meet this test. As you know, last year the administration proposed a recency-of-work test, 6 quarters of coverage out of the last 13 quarters, so we have no problem with the general concept and objectives of this provision. We will, however, need to study section 9 further to look into possible administrative problems, such as the implications of using earnings from noncovered work to establish eligibility.

Section 16 would provide reimbursement for purchased medical examinations to be made through a private SSA carrier selected through competitive bidding and under the reimbursement principles used in the medicare program.

Mr. Chairman, your introductory remarks of March 3 on this provision indicate that this section is intended to assure more accountability to social security for trust funds expended for consultative exams, reduce reliance on volume providers, and improve the quality and reliability of evidence.

I would agree with all those objectives, Mr. Chairman, but it is not clear that section 16 would achieve these objectives. It is possible that the provisions would simply raise fees provided to volume providers as well as disrupt State procedures for obtaining and paying for medical evidence.

We have taken several significant steps to improve our monitoring of State agency purchases of medical evidence. I am submitting an attached description of those steps for the record with my testimony, Mr. Chairman.

Section 13 contains the administration's fiscal year 1983 budget proposal to deregulate attorneys' fees. I notice, Mr. Chairman, that in the introductory remarks of this section you indicate that you want to study the deregulation proposal further before taking a final position. I strongly recommend your favorable consideration of this provision.

The attorney fee provisions are a heavy and ever-increasing burden to administer and are diverting Social Security's limited manpower resources from reducing heavy workloads and claim processing times.

Section 14 emphasizes that social security law does not permit SSA to pay benefits before a final determination of entitlement is made. As you have pointed out, a number of courts have established time limits for adjudication of social security hearing cases, and in a few cases have ordered Social Security to pay interim benefits even though the cases are still pending.

We have consistently taken the position that social security law does not permit us to make interim payments in these cases, and we would welcome statutory affirmation of our position.

H.R. 5700 would make several desirable minor and technical fixes related to the public disability offset provision enacted in last year's budget reconciliation legislation. We are actively considering other provisions in the bill, but have not yet reached firm conclusions on them.

Before concluding, I would like to note the absence in H.R. 5700 of three administration-supported proposals for the disability insurance program. We strongly recommend that your subcommittee consider these changes, which were included in the administration's 1983 budget, that would primarily facilitate program administration and improve or maintain program integrity without basically changing the social security benefit provisions.

The first two 1983 budget proposals are medical evidence and denial notices. These two proposals relate to payment for medical evidence of record and personalized disability denial notices.

The requirement for payment for medical evidence of record would be deleted from the social security disability insurance program. Under the DI program, payment for such evidence has not improved the quality of the medical evidence, as expected. Also, the disability insurance funds required to be expended for this purpose under the 1980 disability amendments are not well targeted and frequently replace available private funds of claimants. This proposal will reduce costs by about $11.4 million in fiscal year 1983.

Also, the provision specifically requiring the furnishing of detailed explanations of denials of social security and SSI disability benefits would be repealed. This procedure continues to be time-consuming and labor-intensive, and does not appear to be leading to improved understanding or acceptance of disability denials on the part of claimants or the public in general. The elimination of this activity is expected to save about $31 million in fiscal year 1983.

The third proposal which we would make would modify the present requirement that we move from the current 35-percent level of preeffectuation review of allowances of disability insurance benefits to a 65-percent review in 1983. As required by the conferees on the 1980 disability amendments we reported to the Congress last fall on the cost effectiveness of the preeffectuation review process and the appropriateness of going to the 65-percent level.

In short, we found that while preeffectuation review has been highly cost-effective, a shift to 65 percent next year would clearly not be as cost-effective as the 35-percent level and indeed might not be cost-effective at all. There are several reasons for this. One, SSA is targeting the reviews so that the most errorprone cases are already reviewed. Also, an increase to 65 percent would require a substantial increase in staffing and the use of relatively untrained and therefore less productive personnel in carrying out the review. The administrative costs associated with moving to a 65-percent review would be about $9.5 million in fiscal year 1983.

We do not think that the level of preeffectuation review should be increased until we have further experience at the current level and evidence that an increase is desirable. In addition, we would favor a change in the preeffectuation review mandate that would give us the flexibility to review both favorable and unfavorable determinations.

The requirement that we review only favorable determinations leads to a built-in bias in the system that results in States using a rule of "when in doubt, throw it out."

In conclusion, Mr. Chairman, I believe that H.R. 5700 by and large is a constructive approach to some of the administrative problems the social security disability program faces today. We will be studying the bill further, and will be making additional comments, Mr. Chairman, and we stand ready to provide technical assistance to you and other members of your subcommittee and your staff.

Before I conclude, Mr. Chairman, I just might add, I know of your interest in the problems that we have had in the systems area, and I am afraid that I have one to report. We had a little problem this past weekend—I just thought I would mention it to the subcommittee—where we had a software problem in our automated job stream system that caused our computers to convulse, so to speak. We sent out about 2,000 overpayments of about $5,000 apiece.

So, you will probably be hearing shortly from constituents regarding a rather massive overpayment of about $10 million. The error rate was only about 2 percent, but we have sent these overpayments out. We have notified the overpaid beneficiaries today. We are notifying our field offices to go back out and to contact all of the beneficiaries who have received those checks, and to provide them with ways of repaying the money.

I think it is just indicative, Mr. Chairman, of what we have talked about on so many occasions before this committee, the problems that we do have in the systems area, and they do cause us trouble in disability insurance as well as old age and survivor's insurance.

With that, Mr. Chairman, I will conclude my statement, and I will be pleased to answer any questions the subcommittee might have.

[An attachment to the statement follows:]

SSA ACTIONS TAKEN TO IMPROVE MANAGEMENT OF CONSULTATIVE EXAMINATIONS

Listed below are brief summaries of a wide range of actions taken to improve consultative examinations (CE's). These actions have been directed toward providing clear program direction on CE report requirements and maintenance of a quality process as well as establishing a more formal program of monitoring State agencies in this area.

Basic SSA policy was issued in Social Security Ruling 82-14, which covered CE physician qualifications, independence of CE physicians from other program or claimant relationships, content of CE reports, and physician signatures on CE reports.

Detailed instructions have been issued to State agencies in the SSA Program Operations Manual in order to achieve improved CE reports nationally. These instructions cover a broad range of aspects of the CE process including: Selection of CE sources; arrangements for a CE, including provision of pertinent materials in file; report content and signature requirements; guidelines for review of CE reports; specific medical specialty report requirements.

The initial monitoring by SSA of State agency CE management processes has been completed. All States initially provided general descriptions of their practices for oversight of CE's as well as specific data on the "top ten" providers. These responses were analyzed and weaknesses in handling complaints, keeping records, maintaining ongoing oversight and other areas were identified. Regional Commissioners then worked with each State to improve oversight. Followup reports have now been submitted from all regions.

The second stage of SSA monitoring efforts is now underway. An in-depth protocol has been developed for reviewing all aspects of a CE provider's operation and the State agency's oversight of it. Joint SSA-State onsite reviews of 30 CE providers are taking place this month and next.

The next stage in our monitoring program will be the issuance of administrative guidelines to State agencies. These will specify what States must do in their oversight of CE providers. In addition, specific instructions will be issued to Regional Commissioners regarding the need to monitor agency compliance with the administrative guidelines. These materials will be issued by July 1, 1982.

All State agency administrators will be attending the first disability programs management forum next week. The forum will include a series of workshops designed to allow administrators to share problems and solutions for managing the CE process.

Additional technical policy guidelines will be issued in the next several weeks. Such issues as whether CE providers are bound by the Privacy Act and how CE providers should respond to requests for interrogatories by claimant's attorneys have been raised as we have explored the complaints of the legal community concerning CE providers.

We are developing a methodology for review and comparision of CE providers through the case review process. At present, review procedures do not provide for the sampling of cases by CE provider nor are we certain what can be learned from case reviews targeted by CE provider. Studies will be geared to determine whether there are significant differences between CE's done by volume providers and those done by other sources. This should begin later this year.

Chairman **PICKLE**. Well, thank you, Commissioner. You have given us a good statement, and I appreciate your general attitude of giving this bill cautious approval. At least you find many things to be in agreement with, and that is helpful to us.

First, with respect to the overpayment that just occurred, does it relate at all to the difficulty we have in the equipment with social security, the computers, the stress we are under constantly with our systems?

Mr. **SVAHN**. It does, Mr. Chairman. As you know, we were several years behind in processing the earnings reports and the recomputation of benefits. The current problem is a software problem. People had reported income from last year, and we are now going to compute what kind of a change they ought to have in their benefit, some of them being retroactive. It would normally be a month of benefits or something like that, maybe 2 months of benefits, but what happened, we had a problem in the software, and the computers did not take into account the earnings report that the people made to it.

So, we ran about 2,000 out of about 100,000 of them, the first batch, and the system did not account for their earnings, so it paid them a full year's worth of benefits retroactively. So the checks that went out averaged about $5,000 apiece. We found out about it, quite frankly, by some beneficiaries who walked into the office and said, I think there is a mistake here, and of course that immediately alerted us. That was last Friday we found that out.

Chairman PICKLE. And you are recontacting those people?

Mr. SVAHN. All of those people, yes, sir. We will be asking them for the checks back. They have been out there about 2 weeks now. They went out on the 3d. So they have been out there for about 2 weeks. So the chances are most of them have been negotiated.

Chairman PICKLE. Within a couple of weeks, you will have some idea of what kind of response you will have? Will you give this committee a further report?

Mr. SVAHN. I will be pleased to.

Chairman PICKLE. The number of people who have responded and the number of checks reclaimed. Because it will be interesting to know what kind of response you get out of it.

While I don't like to hear this——

Mr. ARCHER. Will you yield?

Chairman PICKLE. I will yield to Mr. Archer.

Mr. ARCHER. Thank you, Mr. Chairman.

What is the normal method that you use to recover repayment of overpayments?

Mr. SVAHN. We contact the individual first. We just this last year started a fairly large program of contacting individuals who have been overpaid. We contact them, notify them of the overpayment, notify them of the reason for the overpayment, and set up a collection schedule. If we have the authority, we will offset against their future checks. Or in many cases, many people just come in and pay the full amount back.

Mr. ARCHER. Does the law grant you the authority to offset against future checks if they do not pay within a certain period of time?

Mr. SVAHN. It does in certain areas, and in other areas we are prevented from doing that, and I am going to have to look to someone else to find which areas they are. I do know there are a couple of areas where we are not able to offset at the present time and we would like to be able to offset.

Mr. ARCHER. Would you like to submit these areas to us?

[The following was subsequently received:]

RECOVERY OF OVERPAYMENTS

The general provisions governing the recovery of overpayments in the OASDI (and SSI) program permit recovery through decreasing future benefits otherwise due the overpaid person (or payable on the basis of his earnings record in OASDI cases) under the program in which the overpayment has occurred. In addition, at the request of the overpaid individual we may recover overpayments made under one SSA administered program against benefits payable under another such program. For example, if an overpaid SSI beneficiary who no longer gets SSI but does get Social Security benefits asks us to do so, we may effect recovery of the SSI overpayment by withholding from future Social Security benefits.

However, we do not now have legislative authority to recover overpayments made under one of our programs from benefits we are paying to the person under another program we administer, unless the overpaid person agrees to this arrangement. As part of our fiscal year 1983 Budget, we are proposing legislation that would permit us to make cross-program adjustments under the programs we administer.

Mr. SVAHN. I will be happy to.

Mr. ARCHER. Thank you.

Chairman PICKLE. Mr. Commissioner, I suppose that we could surmise that section 5 and section 9 might be two areas of concern for your administration as well as this committee and all the groups that would be affected. Section 5 really increases the role of the reconsideration process. First, it closes the record after reconsideration. It lengthens the period of appeal time and reconsideration from 60 days up to 6 months, and it provides a face-to-face hearing.

Now, I cannot tell from your testimony whether you are objecting or just raising some concerns about it. I would like to have a statement from you or the people on your panel if in general you would agree that moving up the reconsideration level would be an improvement, or would it not? Is it an approach we should generally take or consider?

Mr. SVAHN. Let me offer some general comments, Mr. Chairman, and then perhaps I can ask Mr. Hays to make some further comments, and we hope his comments and mine coincide. [Laughter.]

I personally think that something between the initial decision and a full-blown hearing at the administrative law judge level might be desirable. We have been looking at the possibility of setting up some kind of—on a prioritized basis—face-to-face reconsiderations or evidentiary hearings at the local level or something like that, something between the two.

I think we established that principle when I was in California in the welfare system. We had some very severe backlogs of hearings, and we established an evidentiary hearing at the local level, and it worked exceptionally well. It took the load off for the very tough cases. It screened out some of the more frivolous cases, and gave people the opportunity to understand why it was that the State was doing something, so I think it was in the main beneficial, but I would like to ask Mr. Hays to comment.

Chairman PICKLE. Mr. Hays, would you like to comment on this further?

Mr. HAYS. Well, with respect to the provisions directly relating to closing of the record at reconsideration, certainly from a workload standpoint at the administrative law judge level, that would seem to have a beneficial effect, if for no other reason than the fact that the cases we would be getting at the appeals level would be fully developed when we received them, and it would cut down, one would assume, fairly substantially on the processing time that currently it is taking to hear and decide decisions at the ALJ level.

It is also conceivable that, in addition to decreasing the processing time because of the reduced development time, we might actually receive fewer requests for hearings, because it is possible that claimants might be more fully satisfied with the results of the reconsideration stage than they currently are.

So, looking at it purely from a workload standpoint at the ALJ level, it appears to us at this point to have a beneficial effect on the process.

Chairman PICKLE. Could you venture a reaction of the attorneys in general? Will the lawyers favor this reconsideration level, or would you venture an cpinion on that? What about the ALJ's?

Mr. SVAHN. Well, Mr. Hays is here representing the Office of Hearings and Appeals. I think that in the main anything that streamlines that process would be found to be favorable with the ALJ's. I think that most attorneys would be concerned about due process, and as long as we have built in the kinds of things that are necessary there and protect an individual's right to due process, it would be perfectly fine. Now, there is a growing industry of persons in the legal field who might not like that and might not like some of the other provisions in this bill, but we will have to let them speak for themselves.

Chairman PICKLE. Well, I know we will be hearing from them. We just wanted your comments.

What we are concerned about generally is the reconsideration process now sort of is a sham. An affirmance rate of 87 percent and an appeal rate of 60 percent indicate that attorneys are avoiding this stage. They are just simply skipping reconsideration and going right up to the appeals level. That is creating a great deal of backlog as well as postponing decisions and evidence of record which we should have at an early stage. That is the purpose of this section, and so we will be hearing from some of these groups, and we would like any further comments from you. If you can give us a further report about advantages or disadvantages of this particular section, it would help.

Mr. SVAHN. We would be happy to.

Chairman PICKLE. Just a couple more questions, if the committee will permit me.

Section 9 may be somewhat controversial to various groups because it would provide 2 out of 6 years' participation in the program to be eligibile for disability benefits. I do know there are some groups who have commented to us, and we will probably hear from them during this hearing, that they are going to equate this with the administration's suggestion that last year you proposed 6 out of 13 quarters, which many would consider rather harsh. You have just got to make a reference to that as one of the matters you were going to recommend.

We have to make the observation that if we go one of the two routes, which way? If we go to the 6 out of 13, we affect about 36,000 people each year. If we go 2 out of 6, we would affect much fewer, as few as 1,000 a year, or at least that is the preliminary estimate.

Now, somewhere in between we may have to decide what figure, if any, we have to take, but that is the reason for it.

The recency of work may be a controversial question. We would like to have any further comments from you. I get your recommendation that you want the 6 out of 13.

Mr. SVAHN. I just commented on the fact, Mr. Chairman, that we had proposed that last May, and as you know the President withdrew those proposals in September.

Chairman PICKLE. Well, that gives us a little leeway, then.

I have other questions, but I want to ask the other members first if they have questions for you.

Mr. Shannon, do you have any questions of the Commissioner?

Mr. **Shannon**. Thank you, Mr. Chairman.

Mr. Commissioner, thank you for this testimony. Just a couple of quick ones. I have seen some statistics that indicate that the percentage of claimants who were denied benefits at initial application has gone up about 50 percent in fiscal year 1981 to over 60 percent of all applicants. What is the reason for this rise in denials? I know that some of this was put in place before you came into office. I am not laying an undue burden on you. But is the definition of disability changing.

Mr. **Svahn**. No, the definition of disability has not changed, Mr. Shannon. I am a little surprised that it went up in fiscal year 1981 that much.

Mr. **Shannon**. I am sorry. It was over the last 4 or 5 years. It has gone up around 50 percent.

Mr. **Svahn**. It has gone up substantially.

Mr. **Shannon**. In fiscal year 1981 it was a 60-percent rate, and a 41-percent rate in 1976, I think, or 1977.

Mr. **Svahn**. There has been no change in the definition of disability. I personally have been struggling with this program for the last 10 months, trying to figure it out, and I think I have come to the conclusion that it doesn't make commonsense. We have a program where we have a denial rate of something like 60 to 65 percent on the front end, and where, by almost all estimates, including the GAO's, we have something between 20 and 30 percent of the people who are currently on the rolls that do not meet the current definition and probably did not when they originally came on the disability rolls.

Then we have the very high reversal rate under the appeals process. I think that one of the things that is happening is that States, the DDS's, as I mentioned in my testimony, are being reviewed on a high percentage of the cases that they grant eligibility, and are not being reviewed on any of the cases on which they deny eligibility.

Mr. **Shannon**. Why is that?

Mr. **Svahn**. Well, that is because that is the way the current process in law operates. We are required to do——

Mr. **Shannon**. Maybe that is something we should address in this legislation.

Mr. **Svahn**. I think we are, and I think that from an administrative standpoint, we at Social Security are trying to address it even right now. As I mentioned in my opening statement, we are trying to see how within what we have in terms of resources, we can review more of the denials, the same as we sample some of the approvals, and go through and at least neutralize the process.

Mr. **Shannon**. Would it be possible to legislatively require a parity of whether it be denied or allowed, that there should be a roughly equivalent review of cases?

Mr. **Svahn**. In general I have a problem with setting up numbers in the statute, because there is no satisfactory way to set it up. As I said, administratively, I am trying to find ways where we can sample more of those denials. I would like to have the authority to do that. I think we can do it.

It is a question actually of whether I can use some of the resources that I have got now for preeffectuation review, and use some of those resources for sampling denials as opposed to just allowances and continuances.

Mr. **Shannon**. Do you have any statistics or any data at all as to what happens to people whose benefits are cut off? How many of those people end up back in the work force, and how many of them end up on some other either general relief rolls or State programs?

Mr. **Svahn**. No, we don't have any statistics on that.

Mr. **Shannon**. I wonder if there is any way that kind of data could be compiled, because it is my impression, and I do not have any statistics either, that many of them do end up destitute as a result of the denial, and not back in the work force, and I would probably think that is worse than the situation like we have today with the high unemployment rate, and it would really be helpful to the committee if we could get some kind of a picture on that.

Mr. **Svahn**. Well, we do not collect any kind of data or anything like that that would do that, and I do not know whether we have any surveys or anything like that that are in process.

Mr. **Shannon**. We take people up to the point where they go off the rolls. I am just wondering how cost effective ultimately all of this is, and how many of those folks end up being on some other rolls at some level of government. I know it is difficult to compile that data, but perhaps we could work together to try to figure out a way of sampling that and getting a sense of that.

Mr. Chairman, with your indulgence, if I could just ask one more question.

Chairman **Pickle**. Go ahead.

Mr. **Shannon**. Mr. Hays, I am a little bit concerned about the memorandum which was sent to the administrative law judges concerning the Ninth Circuit Court of Appeals decision last year which upheld that the SSI benefits based on disability of a claimant converted from the State welfare rolls to the SSI program in January of 1974 couldn't be terminated unless SSA showed that there was either a material improvement to the actual condition or a clear and specific error in the prior State determination.

I know that standard differs from the standard which had been established in SSA. What concerns me, I guess, is the memorandum which you sent to the ALJ's suggesting that this standard should not be applied. Perhaps you could comment on that, what was going on there.

Mr. **Hays**. Sure, Mr. Shannon. My memorandum, if I recall correctly the one you are referring to, was announcing the formal nonacquiescence of the Social Security Administration in the decision. I believe it was the *Finnegan* case out of the ninth circuit. It is my understanding that it has been a longstanding policy of the Social Security Administration to have a policy of formal acquiescence or nonacquiescence in court decisions.

The reason for that is, of course, that we administer a national program as stated in the Social Security Act, and that the only way that a national program can be administered so that claimants and beneficiaries are treated essentially equally, regardless of what particular State they happen to reside in around the country, is to follow the policy stated in the law and the regulations rather than individual court decisions around the country.

So, in the absence of a U.S. Supreme Court decision or a change in the act or regulations themselves, my memorandum to which you have referred is merely a part of a long-standing process that the Social Security Administration has traditionally used to maintain a uniform national policy.

Mr. SHANNON. I can understand and appreciate the difficulty in maintaining a uniform national policy, particularly when you have so many different courts making so many different decisions, but is it not a problem to you that there should be a circuit court ruling that states one application of the law, and that at your level they should order administrative law judges to basically ignore that court decision?

Is there not some way that that could be worked out?

Mr. HAYS. Naturally, our preference is to get a final ruling from the U.S. Supreme Court that will set once and for all the correct answer to that, but in the interim, we are purely following the normal procedure as confirmed by our Office of General Counsel that this is a proper exercise of our authority to administer the Social Security Act.

Mr. SHANNON. Is there a review process to determine whether standards enunciated by the court may be a more appropriate one, or do you, just as a matter of course, stand by the view that the Social Security Administration has taken?

Mr. HAYS. It is my understanding, Mr. Shannon, that there is in fact a formal process which is conducted through the Social Security Administration headquarters office. It gets formal review by the policymakers in Baltimore, so to speak. This is not something that we just do on an ad hoc informal basis. It is the result of a formal review process.

Mr. SHANNON. Is this particular case going to the Supreme Court?

Mr. HAYS. I have to apologize. I don't recall the status of the appeal of that case.

Mr. SHANNON. I think we would all agree that having uniformity of decisions is an important part of this program, and we appreciate the dilemma, but I am still a little concerned. I understand that it has been a longstanding policy to treat these things similarly, but I am still concerned that we would have a court as high as the Ninth Circuit Court of Appeals make a ruling and put you in a position where you have to contradict them in such a way.

Perhaps we can work through the consideration of this legislation on a process that is more clearly enunciated to deal with these kinds of situations.

Thank you, Mr. Chairman.

Chairman PICKLE. Thank you, Mr. Shannon.

Mr. Archer?

Mr. ARCHER. Thank you, Mr. Chairman.

Mr. Commissioner, Congressman Conable had intended to be here today, and felt it important to be here, but had an irreconcilable conflict in his schedule.

In his absence, I will ask you a question he would have asked had he been here.

In western New York State, there have apparently been a number of instances where people, as a result of a continuing disability investigation, have been terminated, and apparently after only very brief investigations. There are reports there in the press of benefits being stopped on the sole basis of a telephone call in each case. Where it was clearly the intent of Congress to make sure that disabled beneficiaries are clearly disabled, it was equally clearly our intent to give any beneficiary an opportunity for a fair investigation, and be sure that the beneficiaries do not get short shrift.

Mr. Conable is very concerned about this, because apparently it has been particularly true in his area of New York.

I wonder if you would like to comment on it.

Mr. **Svahn**. I would, Mr. Archer. I appreciate that Mr. Conable is asking the question that I asked myself, and that was pointed out by this group that I put together to review the continuing disability investigation program that we have in effect. I guess I go back to my comment that I think we have got a 3-year period here, and I think it goes to what Mr. Shannon was talking about also, where we are in the transition. There is no question in my mind that back several years ago there was a lax administration of the disability program, and that there was a considerable amount of dumping, if you will, by some large States when the Federal Government took over the SSI program, and those people got moved onto the disability insurance rolls in one way or another.

I am very concerned about what the States are doing in the CDI process. One of the things we had decided to do, as a result of this task force I put together, would be to improve the development of the medical evidence of record in the CDI cases. I have found cases where we are making decisions, or the States in our behalf are making decisions, in isolated cases, and on very slim evidence, and sending the beneficiary a letter that says, you are now off disability insurance based on a consultative examination. Given the fact that the person could be on disability insurance for some period of time, we are now going to require more workup of medical evidence of record, and we will be hoping to address that specific problem that Congressman Conable is concerned with.

There are a lot of other areas that we are looking at, trying to work some kinds of administrative changes into this 3-year transition period as we go through and do one-third, one-third, one-third of the current disability insurance cases, and presumably then we will have cleaned the caseload of nonpermanently disabled persons, of cases that are erroneously being paid.

Then we will be in a position where we can institute formal procedures from then on out, but this 3-year period is proving very trying—a very trying period for social security, for the State DDS's, and for all those people who have been on disability insurance for some period of time and are not disabled.

Mr. **Archer**. Have you given us this morning the benefit of any additional recommendations that you might like to see in this bill? Inasmuch as we intend to do a markup in a short period of time, I think that there should be an opportunity for all of the aspects of this problem to be considered.

If you have not given us all of your specific recommendations that you think might also be included appropriately in this legislation, I, for one, would certainly like to have them before we go to markup.

Mr. **Svahn**. Well, I did mention the three changes that the administration had proposed in the budget that we would like to see enacted. We are in the process of reviewing, as Mr. Pickle, the chairman, has asked us to do, the bill in detail and looking to other areas where we might be able to work out some technical changes of an administrative nature or something like that.

That would not affect the basic structure of the program, yet that would make our job an awful lot easier and would be much more beneficial to those people. So we will be providing that information.

Mr. **Archer**. Do you have a timetable as to when you might be able to make those comments?

Mr. **Svahn**. We have been working with the subcommittee staff right along on this process, and I can say that we will meet your time schedule, whatever it is, assuming you are not going to markup tomorrow.

Mr. **Archer**. All right, thank you very much.

Chairman **Pickle**. Mr. Commissioner, let me ask you a couple of questions. First, in your statement you say that you are currently reexamining the status of all disability beneficiaries who are on the rolls. Now, when you say all, does that mean those who are permanently disabled?

Mr. **Svahn**. No, it does not, Mr. Chairman.

Chairman **Pickle**. I have had reports from my own district that those that are permanently disabled have been called in also. This may be true of other members of this committee and this Congress. I would like for you to check with your staff again because we are getting reports of people who say they have been brought in, they have been permanently disabled and so declared, and now they are receiving notice they are going to be cut off.

I wish you would check that point. You are saying you are not sending it to those permanently disabled?

Mr. **Svahn**. We are not, but of course, the definition of permanently disabled, I guess, is technically within our control. As part of this review of the CDI process we have just gone through, I have expanded that definition because again, as I said, I am trying to look at that from a content standpoint. We have expanded the definition of permanently disabled to include people who are older and who have had certain types of illnesses.

Chairman **Pickle**. The committee feels very strongly that the requirement for a review once every 3 years of those people not permanently disabled is proper; that we need to know once every 3 years if they are still disabled, if they are able to work. That is a very appropriate, legitimate question and review to ask.

We did not anticipate, I think the committee would agree, that when we passed this in the last session of Congress 2 or 3 years ago, that the review would start on January 1, 1982, that the administration would have advanced or accelerated that review, and you called in some 300,000 people, I understand, during 1981. I have to assume that the reason for that is primarily to save money, try to get them off the rolls if they are not disabled, for whatever purpose that has happened.

This has caused a problem. We want an orderly yet humane review of these cases, and when you call in 300,000 of them, that is more than a wagonload. [Laughter.]

That is treating them in a very inhumane manner. So I did get concerned about the kind of medical evidence and reviews that they are getting.

You state on page 12 that the payment for evidence of record has not improved the quality of the medical evidence as expected. Now, you told Mr. Archer that as each case is being called in, you are going to ask for stronger medical evidence. Do you want that medical evidence to come from a doctor or the social security program?

Mr. SVAHN. I guess what we are saying, Mr. Chairman, is that by us paying that physician to supply that medical evidence, we are not getting any better evidence than we got when we just asked them for it.

Chairman PICKLE. What is your source of authority on that? Is it Commissioner Svahn? Do the States agree with you that paying for medical evidence has not improved the review of our cases?

Mr. SVAHN. Maybe I could ask Ms. Greenberg to comment on that, although she is suffering a little bit from laryngitis today.

Ms. GREENBERG. I think that the question really has two aspects, Mr. Pickle. The States have given us anecdotal information. They do not have a scientific survey, but they have told us in an anecdotal way that the evidence does not look any different today than it did at the time when we were not paying for it. Whether they would like a change or not is a different question, but they seem to be telling us that the evidence today is no better than it ever was.

Chairman PICKLE. That seems to me just contrary to every logic you would apply to a case of disability: that is, that you want to get the best medical evidence possible. If we, the SSA, are willing to pay for it from our trust fund, I have assumed that we have gotten the best evidence possible.

Now you are telling me that it has not improved from the previous method?

Ms. GREENBERG. I think we are talking, sir, about buying evidence that already exists. I think what happens is that a doctor either has made a good record or he has not, and when we ask him for his records, either it is good or it is not good. And the fact that we are paying him for a copy of his record does not change the quality of it.

Chairman PICKLE. Well, we will have to receive other testimony on that. I am advised that we put this provision in the 1980 act because SSI was doing the same thing, and it just sounds to me like you are just saying we will take the old evidence and not try to get new evidence and not try to get a reevaluation and reexamination.

That does not strike me—Are you going to try to save $11 million if you use the previous examinations, the previous evidence?

Ms. GREENBERG. What we are talking about in this provision is the authority to pay a doctor for his records that already exist. It is not the payment for doing an exam. That we will continue to pay for, of course. This provision goes to the fact that you have seen your doctor, he has office records on you, and we pay the doctor for giving us a copy of those office records.

It looks like we get the same office records whether or not we pay for them. We get them in the same time frames and so on.

Chairman **Pickle**. Well, I had mentioned just 1 minute ago that we had included that provision in the 1980 act. Now, would you make this also applicable to SSI, not require medical evidence for SSI either? Any change of that?

Ms. **Greenberg**. The difference between the DI and SSI is that SSI is a needs-based program. In the SSI case, the individual may have a different relationship with his physician. The fact that we are paying does get us a different result.

Chairman **Pickle**. Well, I want to talk to you further about the medical evidence in the record, and particularly on the volume provider. I as an individual am not happy at all with the method being used by volume providers. It seems to me like it is ridiculous to assume that we can get qualified examinations of 40 to 60 people in 1 day.

Mr. **Svahn**. I understand that you had a consultative exam here.

Chairman **Pickle**. Yes. You have observed that if you use the volume provider, all that would come from it would be you would be paying higher fees. Now, whether that would be the development or not, the question is we need to get the best medical evidence of record that we can.

Mr. **Svahn**. My problem, Mr. Chairman, and I was not involved in your hearing, as you know, my problem is that I know I am not in a position to determine whether or not the so-called volume provider is practicing good medicine. I am just not in that position. I do have some physicians on my staff who have reviewed it and we have talked to the AMA about it. I am not in a position to say they are practicing bad medicine.

I think we have to look at the situation. We have, as I pointed out, made some significant changes in the way we do consultative examinations. I agree with you I want the best medical evidence and the best medical record we can get in order to make these determinations.

Chairman **Pickle**. Well, Commissioner, we are going to submit to you several questions because in the interest of time we want to go ahead and hear from the other witnesses. I see that Senator Riegle has now come into the committee room. We will submit additional questions to you. We would ask you if during the week you and your staff would give us any further recommendations on the bill, because if we do proceed with the markup next week, we would like to have comments on any section that you would care to make.

Mr. **Svahn**. We will do that, Mr. Chairman, and we appreciate the opportunity.

Chairman **Pickle**. We will now ask Senator Don Riegle if he will take a seat at the witness table.

Senator Riegle, we are glad to have you back with us. You served with us here in the House and now you have become a senator, and you are the best example of the Smith Barney advertisement. I guess you could say you have earned it, and we are pleased to have your particular testimony on the bill.

We welcome you, and you proceed.

STATEMENT OF HON. DONALD W. RIEGLE, JR., A U.S. SENATOR FROM THE STATE OF MICHIGAN

Senator RIEGLE. Thank you, Mr. Chairman. It is a great pleasure to appear before you and your colleagues. Congressman Archer, it is a pleasure to be back with you.

I have with me two members of my Senate staff, Susan Manes and David Krawitz, that I would like to have here in the event that questions arise that they may be able to respond to.

I want to say at the outset how much I appreciate this initiative on your part. The fact that it is being undertaken on a bipartisan basis to deal with this problem is really critical. I want to commend you, Mr. Chairman, and also Congressman Archer in taking the leadership in fashioning a comprehensive bill that is designed to confront what is clearly a very difficult problem.

It seems to me your bill goes a long way to dealing with the current law that results in extreme and often unnecessary hardship for thousands of social security recipients.

I have some suggestions that I would like to make that would enable us, I think, to strengthen the objectives of the legislation and protect the rights of the beneficiaries while assuring that only eligible people actually receive the benefits.

I have a fairly lengthy statement, Mr. Chairman, that I would like to have put into the record in its entirety, and I just want to quickly summarize the heart of it in terms of the terrible problem that has arisen in the country that we need to get out into the light of day.

I believe a lot of what is happening is unnecessary and is unjustified, and I want to give you some specific examples in terms of how well-intentioned efforts to reform abuses can in fact go too far, and how when they go too far they can wreak incredible havoc on the least fortunate people in our society.

Almost two-thirds of the terminations of current beneficiaries by the Administration since their voluntary implementation of the review requirements of the 1980 amendments were actually reinstated after appeal. The most recent data show that 69 percent of those individuals who are thrown off the disability rolls were forced to find alternative funds for basic subsistence, perhaps by selling their homes or essential possessions that they have earned over years of work in the work force, and were later actually proven to be eligible for disability benefits.

Even when those individuals who are mistakenly thrown off the rolls later receive retroactive payments covering the period when their benefits were terminated, their previous financial status is often irretrievable. In addition, many of these individuals will lose up to 25 percent of their wrongly terminated benefits which they have to pay in attorney's fees to go through the legal process to become reinstated for a benefit that they were eligible for all along.

I think these figures are a serious indictment of the system and strong evidence that we need major revisions in the CDI procedure.

I have seven regional offices over the State of Michigan as the senior Senator for our State. We have seen our social security disability caseload increase by as much as 95 percent since March of last year. In addition to individuals who have already received termination notices, my regional offices are receiving telephone calls from current recipients who are worried sick about their cases because they are under review, and they are concerned about the prospects of being terminated.

Beneficiaries are not the only individuals contacting my office expressing concern about the current CDI program. I have also been contacted by disability examiners from the Disability Determination Office. These are the individuals at the frontline of the disability review program. After holding meetings in my offices with examiners, we found that the examiners themselves feel that many of the terminations are wrong but the new Federal guidelines tie their hands so much that they are unable to do anything about it.

This is especially evident in cases involving mental impairments where vocational criteria are no longer considered and an IQ must be under 60. These rigid determinations have bizarre results where individuals committed to the Michigan State Psychiatric Hospital are considered no longer disabled and have had their benefits terminated.

Heart disease is another area resulting in a high percentage of denials as a result of these new POM's. The manual is very specific about the degree of occlusions that must have occurred and required the EKG and treadmill evidence be presented. Now, when a patient is unable to take a treadmill/EKG as a result of his or her doctor's advice, they are terminated because of a lack of evidence to prove the claim.

The Social Security Administration will not accept any other tests or other evidence as an alternative to the treadmill. I had one man come to me in Michigan, this is a leading citizen in our State, to say that his brother had been given a death sentence by the Social Security Administration.

I said, "What do you mean by that?"

He said, "Well, my brother is so severely disabled that his doctor feels that he would not survive a full treadmill kind of an examination because his health is so bad." The doctor's feeling was that the man would die as a result of that kind of intense exertion, but he was told that he had to go and get that test. So the family had rallied around and said, look, we don't want to run the risk of that, so under the circumstances, if there is no recourse, you will just have to lose your disability in order to not have to take that test which they felt would kill him, and now the family is contributing money to try to sustain this person and his family so the person can remain alive.

Now, that is the kind of nonsense and heartlessness that I think is built into these new criteria that have not to a large degree been ferreting out those people who ought not to be getting benefits but are in fact knocking many people off the rolls who are disabled, and need the help, and who are worried sick. And many of them, I think, are getting sicker as a result of this pressure.

When I see the way the money that is allegedly being saved here is being squandered in other areas of the budget, it really raises my blood pressure. I think this harsh and overzealous attack on our Nation's older citizens is ridiculous.

On November 5, 1981, which was not that long ago, a Lansing man who had been receiving social security disability benefits since 1967 as a result of a severe back injury stood outside the local social security office and killed himself with a shotgun shortly after discovering that his disability benefits had been terminated. Numerous other suicides have been reported around the country as a result of the CDI's.

Another case being monitored by one of my regional offices in Michigan today concerns a 38-year-old man who is terminally ill. He is suffering from leukemia. He has ploycythemia vera, which is a blood disease, chronic arthritis, hypertension, severe bone pain from both cancer and hepatitus, along with a severe personality disorder associated with a history of both drug and alcohol abuse.

The Social Security Administration says the extreme debilitating bone pain associated with cancer is no longer a factor for consideration. This man's problems are so severe and he is so depressed that the doctor will not allow the family to tell him that his social security disability benefits have been terminated.

So this is what we have got going on in this country. These are just a few specific cases. I can give you as many cases as you want. We could stay here the rest of the day. This is happening all over the rest of the country. To have this be done in the name of economy in Government is just really an outrage. It is really an outrage. It is an abuse and it is an abuse of power and it is something that we have to deal with.

It troubles me very greatly because we see other areas of the Federal Government that are bloated, out of control, waste going on every single day, and basically little, if anything, is being done about it. What has happened here, I think, is an attack on the people in our society least able to fight back, and the fact that they have to go out and hire expensive attorneys just to assert their rights is just not the way it should be. It is not what our Government is about, it is not what it should be about.

I am all for tightening the program to find people on the rolls who do not deserve the benefits, but we cannot have a wholesale attack on the system and on the people here who desperately need this help, because in many cases they are being driven into more severe health problems, if not actually into conditions where they are taking their own lives because of the desperation they feel.

We can do better than that. I am prepared, Mr. Chairman, not only in the course of my full statement, which, as I say, I have asked to be made part of the record, but in any other way we can be helpful to try to show illustrations of what is going on here. I think it is essential that you follow through on this work and I want to be helpful to you in every way I can.

I thank the committee for hearing me out today.

[An appendix to the statement follows:]

APPENDIX

SPECIFIC COMMENTS ON H.R. 5700 BY SENATOR DONALD W. RIEGLE, JR.

Let me briefly discuss the specific provisions in H.R. 5700. The sections of H.R. 5700 that strengthen the reconsideration process, establish uniformity at the various levels of adjudication, and create a Social Security Court, all speak to the need to fine tune the review process with the objective of trying to reduce the number of reversals on appeal. My concerns about all of these provisions is that such fine tuning is achieved by significantly tightening and narrowing the definition of disability. The way in which this bill attempts to attack the problem of wrongful termination is—in essence—to redefine the definition of disability, eliminating many currently eligible individuals. I do not believe that Congress should narrow the already strict definition of disability in the Social Security Act and thereby disqualify individuals with the types of severe conditions I mentioned earlier in my testimony.

I strongly urge the Subcommittee to consider achieving uniformity in the decision-making process by requiring the Social Security Regulations and the Program Operations Manual (POMS) to be redesigned so as to be in conformity with the requirements in the Social Security Act and the judicial precedents established in Federal Court. As the bill is currently drafted, uniformity would be achieved by nullifying judicial precedents and by requiring the adoption of the new Regulations and strict POMS standards at all levels of adjudication. By adopting the Federal Court standards at the first level of re-examination, thousands of disabled beneficiaries will be spared the unnecessary anguish of wrongful termination.

I strongly support the provisions in the bill that extend the option of the recipient to continue to receive benefits after intial notification of termination until a face to face evidentiary hearing is held. This would establish uniformity with the current procedures in the SSI program and would lessen much of the hardship experienced by many beneficiaries who are currently thrown off the rolls in a number of weeks. A similar provision is contained in S. 1944, a bill introduced by Senator Levin, on December 11, 1981, of which I am a cosponsor. I am concerned, however, that the six month limit in H.R. 5700 for such continued benefits may be an insufficient amount of time in some parts of the country where there is a significant backlog of appeals.

I am also concerned about the provision of the bill that would close the record after reconsideration rather than after a hearing in front of an Administrative Law Judge (ALJ) which is the practice under current law. Many beneficiaries do not seek counsel until the ALJ hearing and therefore have inadequately developed records at the reconsideration level. Until we are assured that the reconsideration process will not continue to be pro forma reaffirmation of the initial determination, a fair and complete appeals proceedings can not be assured if the record is closed after the reconsideration level. I recommend the Subcommittee postpone the enactment of this provision awaiting evidence that the reconsideration process has become a meaningful level of review.

In addition, I am strongly opposed to the provision which alters the recency of work test. In a state like Michigan, where unemployment is a significant problem, many newly disabled individuals out of the work force for several years, due to their inability to find employment during difficult economic times, will be denied benefits. The objective of the Social Security Disability Insurance program to provide funds for lost wages due to a severe disabling condition, would still apply to individuals out of the work force for a few years due to their inability to secure employment.

I would also like to briefly discuss those sections of the bill that deal with vocational rehabilitation. I strongly support the concept that those individuals terminated from the Disability rolls as a result of CDI's are in particular need of vocational rehabilitation services and counseling. Many of these individuals whose benefits are terminated as a result of CDI's, have been on the disability rolls for many years and are almost immediately thrown into a position where they must either seek employment or sell most of their possessions in order to qualify for welfare. The additional funds made available under this bill to provide these individuals with vocational rehabilitation services will help assure that no one is forced to seek welfare for lack of vocational and rehabilitation counseling. I would however strongly urge the Subcommittee to consider the proposed program outlined in S. 1987 for providing vocational rehabilitation funds to the states for SSDI and SSI beneficiaries and adapt this program to meet the needs of CDI's. The bill, of which I am a cosponsor, was introduced by Senator Cranston on December 16, 1981, and provides the states with adequate funds for the specific purpose of rehabilitating Social Security Act beneficiaries without additional strain to the Disability Insurance Trust Fund and could be easily modified so as to address the specific problems confronting newly terminated CDI's.

Chairman **Pickle**. Thank you. Your entire statement will be made part of the record.

I would like to ask that you submit to us comments on the bill by sections or items of consideration. We would like to have your suggestions. You said you might submit them. So if you would do that later, we would like to have them this week if you could submit them.

Senator RIEGLE. We have those, Mr. Chairman. We can convey those to you today.

Chairman PICKLE. Let me say at the outset that we are mindful that when the Social Security Administration has called in such a large number of people. Inevitably and inexorably a lot of people would be called in who really should not have been, and it really does frighten them, and some harshness has occurred. It has in my district and, I am sure, in Mr. Archer's and Mr. Shannon's. That was not the intent. But when we call in that large a number of people, it is inevitable that that kind of result would happen.

One purpose of this legislation we have before us is to try and slow down the process in a manner that would be a little more considerate and a little more humane and prevent the type of extreme fear that has resulted and some harshness.

So we agree with you that we should—and I do not think this was intended by either the Social Security Administration or this committee or the examiners, and somewhere in between we must find a more orderly process. I hope the committee can come up with legislation that would keep us more in line with guidelines that are understood and understood by all for the practice of all.

Senator RIEGLE. Would the Chairman yield for just a moment?

Chairman PICKLE. Yes.

Senator RIEGLE. I am concerned—and I must say to you frankly as a member of the Budget Committee in the Senate—that I think part of what is going on here is an attitude within OMB and other agencies within the executive branch designed to wring out savings. We all want to reduce the deficit, but I think there is undue pressure being focused in certain areas where the constituency groups are the least able to fight back. So that there is the appearance that you can go get a quick, easy savings in budget terms by squeezing down these outlays.

As a matter of fact, this group is probably the group in our society least able to stand up to that kind of governmental assault. I am really disturbed about it because I do not think it is fair. I think the numbers show it is excessive and I think it is just something that we have got to move to correct.

Chairman PICKLE. Each case ought to be justified. We would agree with you on that. I must observe, though, Senator, that 2 years ago we had a lot of criticism that we were too lax in the program. We had a lot of people who got on disability, rode it through to their retirement days and then shifted over to the retirement program. We made some corrections in the law 2 years ago, and it has been a good, healthy step. We are trying to make further adjustments.

I commend the people on the disability roll to this extent, that the Social Security Administration, the Congress has said to them, if you can engage in substantial gainful employment, you ought to do it. An individual is happier. They are better members of society if that person is working and not just falling back on disability and feeling like they get some money, riding through the rest of their life on it. It is harmful to that individual and to society.

So we are trying to establish a proper balance. That was the purpose of that legislation 2 years ago, and again the purpose of the legislation before us.

I am particularly pleased that you endorse the concept or the principle we are trying to establish in this legislation.

Senator **Riegle**. I do, indeed.

Chairman **Pickle**. And we hope you will give us the concrete suggestions you have.

Mr. Shannon.

Mr. **Shannon**. I would just like to thank you for your testimony. We know your State has a high rate of unemployment. My State is doing better. It has a healthier economy, but we are running into the same problems.

I got a letter just last week from a constituent who had been terminated after 6 years receiving disability benefits. They sent her to a cardiac surgeon to look at a spine problem. They sent her to a psychiatrist to check out a vision problem. She was running around to the Massachusetts General Hospital two or three times, and she was denied benefits.

I know this lady. There is no way in the world this woman can work, even if there was a job available, and in your State there are not any jobs available. I would like to ask you, and I know this is difficult to determine, but have you ever run into anybody in any of your district offices who have come in who have been terminated who have been able to go back to work?

That is kind of a tough question.

Senator **Riegle**. Let me answer two ways. As you say, right now the employment levels vary. We are at 16 percent in Michigan today, and that does not include an estimated 95,000 additional who have exhausted their benefits so they don't get counted. So in Michigan today, even a person who is reclassified under disability and sent out to find work would find it virtually impossible. There is literally no work to be found on the margin in Michigan today.

I am sure there have been occasions, although they would be rare indeed, where people on disability were reclassified who were able to work have, in fact, gone out and found gainful employment. I agree with the chairman. To the extent that anybody is in that situation, I am all for that.

In fact, I would be willing to spend some money to get people off disability and back into jobs. I think there are an awful lot of people who are in that situation but if they are in a borderline category and thought they could work and would willingly go into a specialized training program, or if they had limited capabilities, would go into a job that was suited to their particular skills that they might have and so forth.

I am all for that, but I think that is a very small part of what we are dealing with here. Not that it should be glossed over, but I think we have to keep it in perspective. A large part of the problem we have today are people who are genuinely disabled and who are in very bleak circumstances and have no other place to turn. Those are the people that I think are being run over right now by these new procedures, which I think are basically designed to try to wring out a few extra dollars. I think that is the essential im-pulse, and by going after a weak constituency that cannot fight back.

Mr. **Shannon**. I supported Chairman Pickle's bill a few years ago to put some work incentives into the bill. I thought it was a good piece of legislation. But these changes really do something else, I am afraid. I think we are going to have to change this whole process, and I look forward to working with you, Senator, to try to tighten this up and make it a much fairer process for the people of this country.

Thank you.

Chairman **Pickle**. Mr. Archer.

Mr. **Archer**. Senator, thank you very much for coming before us. I appreciate your approach that we should eliminate those who are truly not disabled because it is a burden on everybody else in the program, and yet we should be very sensitive to those who are. As the Chairman said, we are trying to establish a balance here, and we appreciate your input on both ends of it.

Chairman **Pickle**. Thank you, Senator. We appreciate your testimony. Come back more often. It will not hurt you a bit.

Senator **Riegle**. Thank you. Come see us, too. It will not hurt you a bit.

Chairman **Pickle**. I would ask now that Mr. Arthur E. Hess come forward to the witness stand. I believe he will be accompanied by Mrs. Bernice Bernstein.

Mr. **Hess**. I would like to have the privilege of also having Mr. Samuel Crouch, a former top official of disability administration for many years join me, if he might.

Chairman **Pickle**. Samuel Crouch? That would be fine. He can take a seat with Mr. Hess and Mrs. Bernstein.

Mr. Hess is a former Deputy Commissioner of the Social Security Administration and former Director of the Disability Insurance program, and Mrs. Bernice Bernstein is a former Assistant General Counsel for the Department of HEW, and former regional director of HEW in New York.

I believe that Mr. Crouch was the bureau Director of Disability Insurance.

We are glad to have you.

Mr. Hess, I believe you have a statement to make to the group.

Mr. **Hess**. Yes, I have.

Chairman **Pickle**. I have also a statement and three letters from Mr. Wilbur Cohen, former HEW Chairman, and two other individuals, which will also be made a part of the record.

We would be pleased to have your statement, Mr. Hess. Your entire statement will be made part of the record.

STATEMENT OF ARTHUR HESS, FORMER DEPUTY COMMISSIONER, SOCIAL SECURITY ADMINISTRATION, FORMER DIRECTOR, DISABILITY INSURANCE PROGRAM, ACCOMPANIED BY BERNICE BERNSTEIN, FORMER ASSISTANT GENERAL COUNSEL, AND FORMER REGIONAL DIRECTOR, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, NEW YORK; AND SAMUEL CROUCH, FORMER ACTING DIRECTOR, BUREAU OF DISABILITY INSURANCE, ALL ON BEHALF OF THE SOS COALITION TO PROTECT SOCIAL SECURITY

Mr. Hess. Thank you, sir.

I was Deputy Commissioner of Social Security from 1967 to 1975. From 1954 to 1965 I served as the first Director of the disability program. I was thus responsible over a period of about 10 years for establishing and administering during its formative period the program on which you are holding hearings today.

We have been asked by the officers of the Coalition To Protect Social Security to present this testimony on behalf of that organization. The SOS Coalition is composed of nearly 100 organizations representing between 35 and 40 million adult Americans, almost equally divided in their membership between current social security beneficiaries and current contributors to the system.

We appreciate the opportunity to be heard on H.R. 5700. The official position of the coalition at this moment is summarized in the several letters which you said you would include in the record which come from coalition Chairman Wilbur Cohen.

I refer to the Coalition position "at the moment" because in the less than 2 weeks that H.R. 5700 and your statement in the Congressional Record have been available, the coalition has not been able to analyze and develop a position on all of the provisions that have important long-range implications for the disability program and for social security generally.

Our initial reaction to many of the technical provisions of the bill is favorable in whole or in part, subject in some instances to modifications we intend to suggest. There is a second group of provisions, however, illustrated by those dealing with the appeals process and with an entirely new structure for judicial review that are complex and sweeping in their import.

These require more consultation, time for analysis and an opportunity to develop a coalition-wide consensus before I could speak to them.

Finally, there is one aspect of the bill, section 9, to which we can and do express vigorous opposition; namely, the proposal to establish a new recency-of-work requirement for disability. This provision if enacted would make it likely that many lifetime workers and contributors to the program who are so unfortunate as to be out of a job because of sickness or unemployment or both would lose their disability protection at the very time in life when they may need it most.

I will speak to the reasons for our opposition to this provision in a few moments.

Aside from the substantive comments I will make below, which I hope you will find helpful, I can best summarize the SOS Coalition's position on the entire bill by quoting from the aforementioned letters. Mr. Cohen wrote you last week:

> Sometime ago, I appointed a Committee on Disability of SOS to consider all disability issues. This committee includes persons who have a close and continuing relationship with disability matters. Since receiving your letter, I have been consulting with some of the members of this committee. They have not been able to complete the review of the 59-page bill, nor have I. We need more time to do a responsible policy and technical review.

Ms. Meryl Weinberg of the Association for Retarded Citizens is chairperson of this committee. I had hoped, Mr. Chairman, she could be with us today, but she is testifying before another committee.

Let me now mention just a few among the laudatory provisions that I personally hope the coalition when it completes its study will support, especially if suggested modifications are found acceptable to you. The bill pinpoints a number of areas where applicants for benefits or beneficiaries on the rolls are unfairly treated under present law or in its administrative applications.

Foremost among these are provisions which we agree require early action, notwithstanding the action just announced by Commissioner Svahn, and the assurances that the situation has been corrected. He stated to you, "Last week, we decided to use a commonsense test in making determinations about when an individual had recovered from disability," and further, "Thus we will generally not find that a person medically recovered before the month of our continuing disability determination is liable for a large overpayment."

We think the law ought to eliminate the disastrous results now being experienced and not leave up to present or to future commonsense interpretations by administrators the procedures to ameliorate the precipitous and unexpected termination of benefits for reasons of so-called medical recovery that are resulting from the present vigorous combing of the beneficiary rolls.

The bill would provide relief of various kinds, albeit temporary, to things that we feel are truly not transitory problems. Where a disabled person's benefits are to be terminated for medical recovery, the bill would afford him the option of continuing to receive benefits up to the time of the reconsidered decision, subject to repayment if the appeal has been unsuccessful at that point. This is now provided to SSI beneficiaries.

The bill extends to such persons—after 1984—the right to due process—similar to SSI—by establishing an evidentiary hearing at the State agency level for medical terminations.

Next, it would establish interim "adjustment" provisions, expiring, however, after 1984 to (a) allow benefits for 2 additional months beyond those now provided on termination—that is—4 months in all—for medical recovery cases if the person has been on the rolls for 36 months. We would support 12 months rather than 36.

Counting the waiting period, a person on the rolls for 12 months already has been disabled at least 1½ years, if not more, and usually cannot adjust to a benefit cutoff any easier than one who has been on the rolls longer.

(b) Overpayment of benefits paid in the past would be waived when a finding of retroactive recovery is made and the beneficiary is not willfully negligent.

(c) Vocational rehabilitation programs for evaluation and job services to medically terminated beneficiaries would be authorized at trust fund expenses, but just for fiscal years 1983 and 1984.

In all of these instances, we would recommend that these humane provisions be enacted as a permanent part of a well-functioning termination process. Assuming that after 1984 the existing rolls will have been fully checked and that new so-called diary procedures are kept up to date is a big assumption.

Even so, there is no guarantee that the individual about to be removed from the rolls after medical examination will not suffer psychic trauma and severe economic hardship. At the best level of current process after 1984, beneficiaries will still be surprised, will with insufficient notice have their checks cut off, leaving them without future income, with possible large overpayments to pay back, and with no rehabilitation or job prospects.

An ongoing rigorous process of medical review should minimize the number of such cases, but this very fact should afford being humane and realistic about the situation in which it leaves the person who, let us remember, is still often impaired in body and in job prospects even though he has "medically recovered."

The bill's laudable temporary provisions deserve to be an integral part of the permanent process.

Without time to develop an official position on all of the technical amendments, the coalition nonetheless wishes to express general approval for setting payments for consultative medical examination in accord with medicare provisions; for face-to-face conference at reconsideration, unless, of course, the reconsideration examiner reverses the initial finding on the record; for medical school courses, although we would suggest initially that they be on a demonstration basis; and for establishment of a permanent advisory council on the medical aspects of disability. Additional provisions to which we are favorably inclined are: priority for social security cases in the Federal courts; indexing SGA and trial work levels for increasing wages; and the proposed changes in demonstration projects.

On the other hand, because of the need for legal consultation and for time to consult member organizations to firm up a coalition position, I must regretfully pass over the sweeping proposals to increase the role of the reconsideration process and decrease the role of the administrative law judges by closing the record after reconsideration, and also the proposal to establish a separate social security court system not just for disability but for all social security cases to replace the jurisdiction of the U.S. district courts.

These proposals make an important contribution to the debate on how best to improve the entire appellate process. They are, however, fraught with due process implications that require extensive deliberations by the many parties who would be affected.

In my final comments, I turn to the one provision of H.R. 5700 that the SOS Coalition firmly opposes. Section 9 of the bill would establish a barrier to the eligibility of some disabled workers, in effect providing a double-barreled recency-of-work requirement.

Now, this is not just a tightening up of a process or of evidentiary requirements to make sure that benefits are paid only to the truly disabled. This is a proposal for a fundamental eligibility change that would take away the right to any benefit at all, and to family protection of some men and women who have spent their lives in productive work, but who succumb slowly but inevitably to progressive diseases that take some years to manifest full disability.

Such an eligibility change would be much more damaging to the security of workers than it first appears. When the disability freeze, which operates to preserve a disabled worker's future rights—and which is in effect today—was first enacted in 1954, Congress in a mood of great caution established an extremely restrictive recency-of-work requirement, that is, currently insured status immediately prior to disablement. This is the requirement that Commissioner Svahn reminded you the administration proposed to reinstitute and later withdrew.

I regret to say that back in 1954, this cautionary provision was aimed mostly at women, because women as yet had not entered the labor market in large numbers to establish lifetime careers. It was feared that many homemakers might work for a few years and then retire permanently to raise families, having established rights to disability insurance when they were no longer going to be dependent on their earnings. But in just 4 years, by 1958, Congress dropped that rigid "currently insured" test.

The requirements for disability eligibility were made identical for the freeze and for disability benefits, namely, fully insured status was coupled with the recency test calling for 20 quarters of coverage out of the last 40 elapsed quarters before the onset of total disability. In other words, the test to assure that a worker, whether a man or a woman, was not a person without a need for earnings and without a commitment to work was that he was fully insured and also had worked in at least 5 out of the most recent 10 years. And so it has been for the last 24 years.

It has never been shown that the present recency test the law, which has endured since 1958, has created significant actuarial or other problems. On the contrary, it has enhanced greatly the protection of the program. Men and women who through their mature working years have had protection against the possibility that insidious, prolonged, progressively worsening illness might finally make it impossible for them to continue holding a job have known for almost a quarter of a century that their disability and their old-age protection and their family survivorship protection were assured so long as their last employment was no more than 5 years before disability finally became total in the strictest medical terms.

The proposed new test of recency is not required to safeguard the program against unwarranted outlays.

Mr. Chairman, in your opening remarks today and in your introduction to the bill, you made a statement which I shall not read in detail. You pointed out that the disability program is running well, it is running surpluses, and the percentage of workers on the rolls is the lowest in the history of the program. May I interject and say that your committee is to be commended for having instituted much of the climate of strictness and reassessment that went to putting the program back on its actuarial feet, but there is no need today and no reason in a time of unusually high unemployment to be taking away the disability protection even from a small number of people, who are current workers and in the labor market and who suffer insidious onset of disability.

This is a bad time for a provision of this kind. We have entered a time of unusually high unemployment. There is no telling for how many years to come, mature workers who are displaced in industry and commerce will be unable to re-enter the labor market through no fault of their own. Why expose them to additional economic hazards by cutting back on their disability protection? Why jeopardize the future amounts of their old age or survivor's benefits that they or their families may receive through the derivative operation of the disability freeze?

In summary, this last proposal, section 9, is a proposal to curtail social security protection by establishing a new, more stringent insurance status requirement for a group that is vulnerable to the progressive worsening of diseases of the aging process. We urge you to drop this provision from the bill.

In closing, let me give you the gist of the SOS Coalition position. One, there are good features in this bill that deserve to be reported out promptly. Two, there are other complicated and controversial provisions for which we respectfully ask that you allow at least a month before Subcommittee action so that our SOS Committee on Disability as well as many other concerned parties may assess the testimony at these hearings, may consult with attorneys and other experts, and may consult fully with national organizations concerned with social security, both those that are members of this coalition and others.

Indeed, with respect to the second group of proposed amendments that deal with the judicial process, we see no hurry to act, and we can foresee them getting in the way of the good things that need prompt doing.

Finally, as I reiterate, we vigorously oppose section 9. In any case, the Presidential Commission on Social Security Reform has just begun its deliberations. It seems to us premature and unnecessary for the Congress to undertake changes now that adversely affect the benefit rights under present law without awaiting the across the board recommendations of the President's Commission.

Thank you.

[The prepared statement follows:]

STATEMENT OF ARTHUR E. HESS, FORMER DEPUTY COMMISSIONER OF SOCIAL SECURITY, ON BEHALF OF SOS COALITION TO PROTECT SOCIAL SECURITY

Mr. Chairman and members of the subcommittee: I was Deputy Commissioner of Social Security from 1967 oto 1975. From 1954 to 1965 I served as the first director of the disability program. I was, thus, responsible over a period of about ten years for establishing and administering during its formative period the program on which you are holding hearings today.

I have been asked by the officers of the Coalition to Protect Social Security to present this testimony on behalf of the organization. The SOS Coalition is composed of nearly 100 organizations representing between 35 and 40 million adult Americans, almost equally divided between current social security beneficiaries and current contributors to the system.

We appreciate the opportunity to be heard on H.R. 5700. The official position of the Coalition at this moment is summarized in the several letters sent to you last week by the Coalition Chairman, Wilbur J. Cohen. These are attached in elaboration of my statement, and I request they be included in the record along with my testimony.

I refer to the Coalition position "at the moment" because in the less than two weeks that the bill and your statement in the Congressional Record have been available, the Coalition has not been able to analyze and develop a position on all of the provisions that have important long-range implications for the disability program and for Social Security generally.

Our initial reaction to many of the technical provisions of HR 5700 is favorable in whole or in part, subject in some instances to modifications we intend to suggest. There is a second group of provisions, illustrated by those dealing with the appeals processes and with an entirely new structure for judicial review that are complex and sweeping in their import. These require more consultation, time for analysis and an opportunity to develop a Coalition-wide consensus before I could speak to them.

Finally, there is one aspect of the bill to which we can and do express vigorous opposition, namely the proposal to establish a new recency-of-work requirement for disability. This provision, if enacted, would make it likely that many life-long workers and contributors to the program who are so unfortunate as to be out of a job because of sickness or unemployment, or both, would lose their disability protection at the very time in life when they may need it most. I will speak to the reasons for our opposition to this provision in a few moments.

Aside from the substantive comments I will make below which I hope you will find helpful, I can best summarize the SOS Coalition's position on the entire bill by quoting from the aforementioned letters. Mr. Cohen wrote you last week:

"Sometime ago, I appointed a Committee on Disability of S.O.S. to consider all disability issues. This Committee includes persons who have a close and continuing relationship with disability matters. Since receiving your letter, I have been consulting with some of the members of this Committee. They have not been able to complete their review of the 59 page bill, nor have I. We need more time to do a responsible policy and technical review.

* * * * * * *

"In your letter, you indicate the hope to move quickly on your bill and you intend to mark-up the bill shortly after the March 16–17 hearings. We urge you to give adequate opportunity for various groups and individuals to express their views on the many complex aspects of the numerous provisions in your proposal. . . . We urge you to delay any subcommittee action for at least one month so that our SOS committee on disability insurance can consult fully with the national organizations concerned with the disabled, evaluate the testimony presented at the coming hearings and then inform you of our considered views."

Let me now mention just a few among the laudatory provisions that I personally hope the Coalition, when it completes its study, will support—especially if suggested modifications are acceptable. The bill pinpoints a number of areas where applicants for benefits or beneficiaries on the rolls are unfairly treated under present law or in its administrative applications. Foremost, among these are provisions to ameliorate the disastrous results now being experienced by the precipitous and unexpected termination of benefits for reasons of "medical recovery" as a result of the vigorous combing of the beneficiary rolls. The bill would provide relief of various kinds, albeit temporary relief in some cases, to situations that we believe are not transitory problems.

1. Where a disabled person's benefits are to be terminated for medical recovery, the bill would afford him the option of continuing to receive benefits up to the time of the reconsidered decision (subject to repayment if the appeal has been unsuccessful at that point). This is now provided in SSI.

2. The bill extends to such a person (after 1984) the right to due process (similar to SSI) by establishing an evidentiary hearing at the State agency level for medical terminations.

3. It would establish interim "adjustment" provisions expiring after 1984 to:

(a) Allow benefits for two additional months beyond those now provided on termination (four months in all) for medical recovery cases if the person has been on the rolls for 36 months. (We would support 12 months rather than 36. Counting the waiting period, a person on the rolls for 12 months has been disabled at least one and one-half years, if not more, and usually cannot adjust to a benefit cut off any easier than one who has been on the rolls longer.)

(b) Overpayments of benefits paid in the past would be waived when a finding of "retroactive recovery" is made and the beneficiary was not willfully negligent

(c) Vocational rehabilitation programs for evaluation and job services to "medically terminated" beneficiaries would be authorized at Trust Fund expense for fiscal 1983 and 1984.

In all these instances we would recommend that these humane provisions be enacted as a permanent part of a well-functioning termination process. Assuming that in 1984 the existing rolls will have been fully checked and that new so-called "diary procedures" are kept up to date is a big assumption. Even so, it is no guarantee that the individual about to be removed from the rolls after medical examination will not suffer psychic trauma and severe economic hardship. At the best level of current process, beneficiaries will often have their checks cut off, leaving them without future income, with possible overpayments to pay back and with no rehabilitation or job prospects. An on-going rigorous process of medical review should minimize the number of such cases, but this very fact should afford being humane and realistic about the situation in which it leaves the person who is still often impaired in body and in job prospects. The bill's laudable temporary provisions deserve to be an integral part of the permanent process.

Without time to develop an official position on many of the technical amendments provided in H.R. 5700, the Coalition nonetheless wishes to express general approval for:

Setting payments for consultative medical examination in accord with Medicare provisions.

Face-to-face conference at reconsideration unless, of course, the reconsideration examiner reverses the initial finding on the record.

Medical school courses (although on a demonstration basis) and establishment of a permanent Advisory Council on the Medical aspects of disability.

Priority for social security cases in Federal courts.

Indexing SGA and trial work levels for increasing wages; and

The proposed change in demonstration projects.

On the other hand, because of the need for legal consultation and for time to consult member organizations to firm up a Coalition position, I must pass over the sweeping proposals to:

Increase the role of the reconsideration process and decrease the role of the Administrative Law Judges by closing the record after reconsideration; and to

Establish a separate Social Security Court system to replace the jurisdiction of the U.S. District Courts.

These proposals make an important contribution to the debate on how best to improve the entire appellate process. They are, however, fraught with due process implications that require extensive deliberation by the many parties who would be affected.

In my final set of comments I return to the one provision of HR 5700 that the SOS Coalition firmly opposes. The bill would establish a barrier to the eligibility of some disabled workers, in effect providing a double-barreled recency-of-work requirement. This is not just a tightening up of a process or an evidentiary requirement to make sure that benefits are paid only to the truly disabled. This is a proposal for a fundamental eligibility change that would take away the right to any benefit at all—and to family protection—of some men and women who have spent their lives in productive work, but who succumb slowly but inevitably to a progressive disease that takes some years to manifest full disability. Such an eligibility change would be much more damaging to the security of workers than it appears at first sight.

When the disability "freeze," which operates to preserve a disabled worker's future rights to full social security protection, was enacted in 1954, Congress in a mood of great caution established an extremely restrictive recency-of-work requirement—i.e., currently insured status immediately prior to disablement. I regret to say, this cautionary provision was aimed mainly at women. Because women, as yet, had not entered the labor market in large numbers to establish life-time careers, it was feared that many homemakers might work for a few years and then retire permanently to raise families, having established rights to disability insurance when they were no longer going to be dependent on their own earnings. But by 1958, only four years later, Congress dropped the rigid currently insured test. The requirements for disability eligibility were made identical for the "freeze" and for disability benefits: fully insured status was coupled with a recency test calling for 20 quarters of coverage out of the last 40 elapsed quarters before onset of total disability. In other words, the test to assure that a worker, whether man of woman, was not a person without a need for earnings and without commitment to work was that he or she had worked in at least five out of the most recent ten years.

And so it has been for the last twenty-four years. It has never been shown that the law which has endured since 1958 has created significant actuarial or other problems. On the contrary, it has enhanced greatly the protection of the program. Men and women who throughout their mature working years have had protection against the possibility that insidious, prolonged, progressively-worsening illness might make it impossible to continue holding a job, have known for almost a quarter of a century that their disability and old-age protection and their family's survivorship protection was assured—so long as their last employment was no more than 5 years before disability finally became total in the strictest medical terms.

The proposed new test of recency is not required to safeguard the program against unwarranted outlays.

Mr. Chairman, in your remarks upon introduction of your bill on March 3 you stated:

"Contrary to popular belief, the disability program is alive and working well financially. It is running surpluses which are being used to help pay retirement benefits under the larger retirement program. The percentage of workers on the disability rolls is the lowest in the history of the program. The definition of disability is being tightly enforced by the State agencies charged with making determinations under the direction of the Social Security Administration." (Congressional Record-House, March 3, 1982 H633)

We have entered a time of unusually high unemployment and there is no telling for how many years to come mature, experienced workers who are technologically displaced in industry and commerce will be unable to reenter the labor market through no fault of their own. Why expose them to additional economic hazards by cutting back on their disability protection? Why jeopardize the future amounts of old age or survivors benefits they or their families may receive through the derivative operation of the "disability freeze"?

In summary, this is a proposal to curtail social security protection for many by establishing a new, more stringent insurance status requirement for a group that is vulnerable to the progressive worsening of diseases of the aging process. We urge you to drop this provision from the bill.

In closing, the gist of the SOS Coalition position is as follows:

1. There are good features in this bill that deserve to be reported out promptly;
2. There are other complicated and controversial provisions for which we respectfully ask that you allow at least a month before subcommittee action so that our SOS Committee on Disability as well as many other concerned parties may assess the testimony at these hearings; may consult with attorneys and other experts who have participated in the disability process; and may consult fully with national organizations concerned with social security that are members of this coalition. Indeed, we see no hurry to act on these provisions, and we can foresee them getting in the way of the good things that need prompt doing.
3. I reiterate, we vigorously oppose Sectioin 9. In any case, the Presidential Commission on Social Security Reform has just begun its deliberations. It seems to us premature and unnecessary for the Congress to undertake changes now that adversely affect the benefit rights under present law without awaiting the across-the-board recommendations of that Commission.

Thank you.

S.O.S. Coalition To Protect Social Security,
Washington, D.C., March 9, 1982.

Hon. J. J. "Jake" Pickle,
Chairman, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

Dear Jake: Thank you for your letter of March 5, inviting me to comment on H.R. 5700, the disability amendment bill you introduced with Mr. Archer. I appreciate your thoughtfulness in sending me the bill and your statement which I received on March 8. I am glad to know you are not set on any one provision in the bill. I have tried to retain a fresh view on any innovative proposals.

Sometime ago, I appointed a Committee on Disability of S.O.S. to consider all disability issues. This Committee includes persons who have a close and continuing relationship with disability matters. Since receiving your letter, I have been consulting with some of the members of this Committee. They have not been able to complete their review of the 59 page bill, nor have I. We need more time to do a responsible policy and technical review.

Nevertheless, we have developed a very definite view on one aspect of the bill: we are vigorously opposed to the provision in the bill to provide more recent attachment to the workforce as a requirement for insured status. We will submit a more detailed statement of the reasons for our strong opposition to this provision as soon as possible. We urge you do drop this provision from the bill.

In your letter, you indicate the hope to move quickly on your bill and you intend to mark-up the bill shortly after the March 16-17 hearings. We urge you to give adequate opportunity for various groups and individuals to express their views on the many complex aspects of the numerous provisions in your proposal. Quite frankly, if your Subcommittee moves too quickly before the various groups have an adequate opportunity to analyze the proposals and come to a considered judgment on them, it will complicate our ability to support any legislation in this important area.

I hope that someone on behalf of S.O.S. can testify before your Subcommittee, preferably on March 17. We have requested time.

I plan to be in Austin on Saturday and Sunday, March 13 and 14, as well as on March 15. If you will be in Austin then, I would be glad to have an opportunity to talk these matters over with you.

We appreciate your cooperation.

Sincerely,

WILBUR J. COHEN, *Chairman.*

S.O.S. COALITION TO PROTECT SOCIAL SECURITY,
Washington, D.C., March 12, 1982.

Hon. J. J. PICKLE,
Chairman, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR JAKE: This is in further reference to your letter to me of March 5 and my letter to you of March 9.

I stated in my previous letter the strong opposition of SOS to the provision in H.R. 5700 to require, in addition to the presently insured status qualification condition (5 out of the last 10 years) that a disabled claimant must have a more recent attachment to the labor force (2 out of the last 6 years).

This added provision would constitute a serious deliberalization of the social security program, and is similar to one of the proposals made by the Reagan Administration in May 1981, and subsequently withdrawn.

If enacted into law, this provision would make ineligible over the years many thousands of totally disabled people who can get benefits under present law, because it would require a much stricter test of recent employment.

When the disability insurance program first became law in 1936, an individual to be eligible had to have worked not only during five years out of the last 10, but also during a year and a half out of the last three years. The test of very recent employment was removed from this program by Congress because it became clear that many totally disabled individuals who had contributed substantially to social security were being barred from benefits unfairly.

Many total disabilities do not occur at a precise moment in time. Unlike the person disabled in an automobile accident or by a stroke, for example, a worker may suffer from a degenerative illness that gets gradually worse. Since the definition of disability for social security purposes is very strict—inability to engage in any substantial gainful activity—a worker may be unable to work continually in the labor market for a considerable period of time before he or she meets the strict definition.

Thus it was not unusual to find workers with any one of a number of progressive diseases, such as emphysema or multiple sclerosis, who had a history of intermittent employment over a considerable period before a final determination of disability could be made. Therefore, the Congress recognized there was a "catch-22" situation in which the person was not quite disabled enough to qualify, but had such difficulty keeping a job that when he or she did become disabled enough, it was no longer possible to meet the test of recent earning.

Making more stringent a test of recency than under the present law is firmly opposed by the SOS Coalition, which is composed of approximately 100 organizations, with a combined membership of between 35 and 40 million adult Americans, about equally divided between those currently receiving social security benefits and those currently contributing to the system.

At a time when the Presidential Commission on Social Security Reform has barely begun its deliberations, it seems both unwise and unnecessary for the Congress to rush into making far-reaching changes in the Social Security Act which would deny benefits to many thousands of people who are elegible under present law.

We plan in the very near future to express our position on other aspects of H.R. 5700.

Sincerely,

WILBUR J. COHEN,
Chairman.

ARTHUR FLEMMING,
Chairman, Advisory Committee.

WILLIAM J. DRIVER,
Vice Chairman.

CHARLES SCHOTTLAND,
Senior Adviser.

S.O.S. COALITION TO PROTECT SOCIAL SECURITY,
Washington, D.C., March 12, 1982.

Hon. J. J. PICKLE,
Chairman, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR JAKE: We have been giving further study to the provisions of your disability bill, H.R. 5700. We have not been able in the short period of time available to us to thoroughly evaluate some of the more controversial and complex provisions in the bill. We have written you previously about our strong opposition to the introduction of a more severe test of recency of employment.

We personally are sympathetic to the objective of several of the provisions in your bill, although frequently with some modifications, as follows:

(1) Allow benefits to continue during the various appeal stages (similar to SSI).

(2) Vocational rehabilitation for beneficiaries but on a permanent basis.

(3) Waive overpayments for the period before notice in medically terminated cases, but on a permanent basis.

(4) Allow "adjustment benefits" for four months after month of termination in case of medical termination for individuals on rolls for a substantial period of time. (We would support 12 months rather than 36 and we believe the provision should be permanent.)

(5) The proposed change in demonstration projects.

(6) Setting payments for consultative medical examination in accord with Medicare provisions.

(7) Face-to-face conference at reconsideration unless, of course, the reconsideration examiner reverses the initial finding on the record.

(8) Medical school courses (although on a demonstration basis) and establishment of a permanent Advisory Council on the Medical aspects of disability.

(9) Priority for social security cases in Federal courts.

(10) Indexing SGA and trial work levels for increasing wages.

However, we wish to await the testimony at your hearings with regard to several other aspects of the bill so that we can evaluate the views of experts and attorneys who have participated in the disability process. We urge you to delay any subcommittee action for at least one month so that our SOS committee on disability insurance can consult fully with the national organizations concerned with the disabled, evaluate the testimony presented at the coming hearings and then inform you of our considered views.

Sincerely,

WILBUR J. COHEN.
WILLIAM J. DRIVER.
ARTHUR FLEMMING.
CHARLES SCHOTTLAND.

P.S. Mr. Robert M. Ball, to whom you also wrote, informs me that while this letter is in accord with his views, he does not feel it appropriate to act formally on behalf of SOS while serving on the National Commission on Social Security Reform. Mr. Flemming, as you may know, has taken Mr. Ball's place as Chairman of our Advisory Committee.

Chairman PICKLE. Thank you, Mr. Hess.

Do you wish to make any additional statement, Mrs. Bernstein, at this time, or Mr. Crouch? Do either of you wish to make an additional statement other than to engage in the colloquy?

Mrs. **Bernstein**. No, Mr. Chairman. I would support wholeheartedly the views that Mr. Hess has expressed, particularly with respect to the need for further study concerning the due process implications of the proposed changes in the various levels of adjudication. I would share with you my experience of over 13, almost 14 years as a regional director for the administration in the New York region, when it was my responsibility to know what the implications of various administrative actions were and the views of the personnel, at a time when jobs are scarce, and terminations are occurring in the Federal payrolls.

I sense that the employee staff is becoming particularly sensitive to changes in administrative policies which will be implemented through closer supervision of the results of their actions, so they tend to be much more careful to apply the policies and directions that they receive from their superiors. That may impair the objectivity of those who are involved in the reconsideration adjudication level moreso than might occur in a more impartial review at the ALJ level.

How that should be or can be corrected or achieved is a matter that I am not prepared to respond to at this point, except to emphasize the desirability of consideration of these kinds of factors by the variety of affected interests in the new requirements.

Chairman **Pickle**. Thank you, Mrs. Bernstein.

Mr. Crouch?

[No comment.]

Chairman **Pickle**. First, I want to thank you for your testimony. We appreciate your general endorsement of many of the provisions, and you helped us by listing the various sections that you did approve of. Now, I am mindful of your request that we delay for a month so that all groups can have a chance to comment. I want all groups to comment, and we are not going to be in any rush to close the record or go immediately to a markup if we find that additional time is needed.

We anticipate on the committee basis—we hope to get a disability bill agreed to early this year, if possible, and then go to a miscellaneous social security bill and be prepared to go into some hearings on the financing section that would be corollary to the Commission's hearing. This being an election year, we are going to be limited in our amount of time, so we have to proceed as quickly as we can without being in any rush about it so we can give all groups ample time.

I must remind you, though, that many of these provisions that have been put in the bill that we put in last year have already been adopted by the committee. They have been advertised throughout all of America, so that the general corrections and reforms in some of the disability programs is something we have talked about for over 1 year. I do not think this is a surprise proposal that we have made, and yet we are not going to be unfair to any group or any organization that wants to be heard.

I am also aware of your other opposition, your main opposition, that is to the recency-of-work test. I am sure you were here earlier when Commissioner Svahn testified.

Mr. **Hess**. Yes.

Chairman **Pickle**. The administration had recommended last year that 6 out of 13 as a recency test, as compared to 20 out of the 40 quarters.

We opposed that last year, because we thought that would be too harsh. We have proposed in this bill a much more moderate recency-of-work approach; namely, 2 out of 6 years. In contrast, the volume of people affected, as I stated earlier, the 6 out of 13 quarters would affect some 36,000 people. We do not believe from the surveys we have made that the 2 out of 6 would affect much more than about 1,000 people, so it is not a large number of people, and it is not a moneysaver. It is the recognition of some kind of recency test.

I am wondering, Mr. Hess, Mrs. Bernstein, if you do not object to this because you do not want any recency-of-work test other than what has been the law for 20 years. Is it not more of a philosophic opposition that you are offering, rather than a practical, realistic approach that would update a recency test?

Mr. **Hess**. No, sir. I think that I tried to indicate in my statement that for many, many years 20 out of the last 40 quarters has been considered a test of recency. There has been no actuarial or operating or other evidence indicating that persons who are not truly disabled get on the rolls by reason of that test. There may be persons occasionally who are not truly disabled, yet who get on the rolls by reason of a breakdown in the evidentiary process or otherwise, but we are particularly concerned that the kind of people who are likely to be cut out by a tighter test of recency are people who get sick, who can no longer hold onto their jobs, who have an insidious and worsening condition.

What this provision would say to such an individual who may have had repeated operations for cancer or who may have had all kinds of other conditions from which he has had temporary remission but nonetheless cannot get back to work—and his being out of work is due to the fact that he is suffering from a series of episodes, either progressive illness or repeated episodes—it would say to this individual, if you have worked 2 out of the last 6 years, you are in, but if your disability does not become total until the 3d or 4th or 5th year out of the last 10, then you are out.

Now, that may not affect a lot of individuals in numbers, but it is a matter of great insecurity to persons who suffer from these kinds of illnesses. Part of the essence of social security is a feeling that you have some protection which will not be arbitrarily cut off if you need to have the protection.

I do not know whether Mr. Crouch wants to say anything further about this matter, but it is not an obstinate adherence to a condition which has been in existence for a long time just because we do not want to see anything modified. It is definitely based on the fact that there is a group of deserving individuals, and as I pointed out, this does not affect just their disability benefits. If they cannot qualify for the disability freeze, this affects the potential amount of their old age and survivor's benefits later on, even if they are fully insured.

Chairman **Pickle**. Mr. Crouch, did you want to comment.

Mr. **Crouch**. If you look at the operation of the program under present law, the number of people who are turned down who never really get a disability determination because they don't meet the 20 out of 40 requirement, I think the numbers run something like 20 to 25 percent of the people who file applications are turned down because they don't meet the present insurance status requirement.

In that population, there are many people of the type that Mr. Hess just described, people who lose employment, who are unable to do the particular type of work they did because they have a medical condition which is slowly deteriorating, who by the time they reach the severity of the disability test, they have lost insured status. Even under present law, there has been a lot of concern over the years that the present insurance status test is too strict and operates to people's disadvantage.

There have been considerations at various times of trying to introduce a different concept of disability where you could get the establishment of the disability freeze, for example, without setting up disability benefits with a less rigid test of disability to insure the status of people that had earned it in the past.

I think there are many problems in this area, and this particular proposal, I don't know what evidence there is that such a proposal is needed. It just to me goes in the wrong direction. Even though it doesn't go very far, it is the wrong direction.

Chairman PICKLE. Let me say to you people that I accept your comments in all sincerity, because I know you would not want to have any recency test that is not a good time to apply such a test.

Let me point this out to you, just for the record. Some people have said that the current law may be too permissive. Just because it has been on the books for 20 years does not automatically mean you cannot make some change. Some people say it might be too permissive. In other words, an individual could be out of the labor force for as much as 6 years and still be eligible for benefits.

Now, some would comment that that is contrary to the purpose of the disability law, because the disability program is to replace lost earnings. If you are out 6 years, some people say it is questionable the disability caused a loss of earnings.

I take the position that this new test we propose is very moderate, and it is not a very strict recency-of-work requirement. In some instances, some individuals could be out of work for almost 5 years and yet still qualify under this new test. Let me give you some examples, just so we will have it on the record.

An individual who returns to work after an employment lapse at an average wage level could regain insurance status in as few as 2 months or at most in 13½ months. An individual returning to work at a minimum wage level could regain insured status in as few as 5 months, or at most within 14½ months. And an individual returning to work at one-half the minimum wage could regain insurance status in 10 months or at most in 17 months.

Now, it does not seem to me that those are harsh requirements. I would grant you that it is an additional recency-of-work test, and that what the committee wants to determine is whether we keep it in the bill or we do not. So, on that point, and on the question of the other objection you had, closing the record, those are parts that we will keep under advisement. Not closing the record, the 1-month delay. That was what I was trying to recall.

Let me ask Mr. Archer now if he has any questions of Mr. Hess or the panel.

Mr. **Archer**. Thank you, Mr. Chairman.

We have information on each of you as to what your past roles were in government, but could you tell us what your current occupations are?

Mr. **Hess**. Yes. I retired in 1975, and I have been a member of the Institute of Medicine, and for the last several years I have been a scholar in residence conducting a congressionally mandated study on the need for Federal financing of nursing education. I also for 2 years directed a foundation project sponsored by the Robert Wood Johnson Foundation which had to do with the fate and future of public general hospitals. My interests since retirement have been almost exclusively in the health area, because my work with social security was also as the first director of medicare.

Mr. **Archer**. Mrs. Bernstein?

Mrs. **Bernstein**. I retired about 2 years ago, and since that day have not been employed. I have served as a volunteer to both State and local voluntary agencies, sharing with them my views and experience in their efforts. I have also served on the New York State Department for the Aging in giving them voluntary advice. It has all been pro bono publico.

Mr. **Archer**. Mr. Crouch?

Mr. **Crouch**. I left social security about 3 years ago. The great bulk of the time since then I have been associated with the Center for the Study of Social Policy, which is affiliated with the University of Chicago.

Mr. **Archer**. Thank you very much. I am glad that all three of you are continuing to stay active, because this country needs the benefits of your talents and experience, whether I agree or disagree with you on some things.

I think we have got to establish some basics here. If I understood you right, Mr. Hess, you said there had been no actuarial problems since 1958. Did I understand that correctly?

Mr. **Hess**. Attributed to this provision. Attributed to the 20 out of 40 provision.

Mr. **Archer**. I see. Good. Because there certainly have been problems.

Mr. **Hess**. Oh, yes.

Mr. **Archer**. The original projections for disability were that when fully implemented it would cost $1 billion a year, and we are looking at $20 billion a year in this coming year.

Mr. **Hess**. Yes, indeed.

Mr. **Archer**. So something has been out of control relative to the original projections for disability.

Mr. **Hess**. Yes.

Mr. **Archer**. I am frankly disappointed to hear you at least imply that disability should be an alternative to job availability. You say: We say we should not do anything in the times of high unemployment. I thought disability was a question of whether you were medically able to work or not. Do you really think that we ought to make our judgments based on the job availability? Or do you think we should make it on the basis of whether you are able to work or not?

Mr. **Hess**. No, sir. I certainly make that distinction. This provision in section 9 has nothing to do with the evidentiary requirements or the definition of disability. It has to do with the question of whether the individual has been part of the system long enough so that one can assume that, but for disability, he would be working.

I was simply saying that, especially with respect to the older worker, the mature worker who has had a lifetime association with an industry that is now undergoing great technological difficulties—automobile, steel, and many of the others—that people will not have an opportunity to be reemployed even if they could work at something else while they have this progressive onset of illness.

Everyone begins to get illnesses, aches and pains, limitations and difficulties at some point along in life, earlier or later, and if he is in a job and can hang onto it, he frequently can mask that; or his employer can make allowances for it. But if he loses that job, he competes then with everybody else to try and get back to work.

I am simply saying this shortens his opportunity to maintain his insurance status. It does not mean that in the end, if he has the insurance status, that the strict test of disability should not apply to him like everybody else.

Mr. **Archer**. So you would not in any way imply that we ought to change the implementation of a valid disability test, depending on the job market?

Mr. **Hess**. Oh, no, no. That is, of course, an extremely complex question in its own, but it is not meant to be an implication of my testimony at all.

Mr. **Archer**. Mr. Shannon was making the same comment in his questions earlier. You do assume that there should be a CDI?

Mr. **Hess**. Absolutely. For both Mr. Crouch and I, CDI is nothing new. We have had continuing disability examinations from the very beginning, and both Mr. Crouch and I at various times have presided over the processing of literally hundreds of thousands of those reexamination and termination cases every year.

It is the nature and the application of new standards and processes to so-called medical terminations that we are looking at now that are causing the great problem.

Mr. **Archer**. Do you have any proposals to procedurally or substantively tighten the program to eliminate abuses? As Senator Riegle was saying, we want to be sure that this is fair from all standpoints, and fair to those who pay in for the program, and that it will not be abused by those who are able to work.

Mr. **Hess**. I think that I would have to say that over the last few years, and I have worked in previous years with Mr. Arner and others on your staff, your committee has been in the forefront, and successive administrations have been combing the possibilities for tightening up. There have been a great many changes which I think have minimized what you would call the abuses. I do not want to expand on this, but if I may remind all of us, a lot of the difficulties we got into were due to the development of the black lung program, which was dumped overnight on the social security program, and which has had long and continuous repercussions since in terms of its effect on operations. And also the SSI program. I refer to the grandfathering under the SSI program of many of the people who were on the State disability rolls. Now, it is true, there was a special process enacted to look at those grandfathered cases, but some of the difficulties we are having now still stem from the residuals of some of those massive loads that were placed upon the disability process.

I would say the kind of things that we commented on favorably here that you are trying to do are exactly the sort of things that are needed.

Mr. ARCHER. But there are no additional "tightening procedures" that you recommend?

Mr. HESS. At the moment, I have no additional ones.

Mr. ARCHER. Thank you very much.

Chairman PICKLE. Mr. Hess, I want to thank you for your testimony. I particularly am pleased that on page 3, 4, and 5 of your prepared testimony you list some 15 different areas of general agreement of this bill. That is helpful.

Mr. HESS. May I add, I think Mr. Cohen would say that he is working very quickly to try and get positions which will be in harmony on some of the other provisions, too.

Chairman PICKLE. I am sure Mr. Cohen is. He will make a very valuable contribution, because no one in America knows more about the social security program than Mr. Cohen. I am privileged to talk to him quite often, since he is in my back yard. [General laughter.]

He is in my back yard, front yard, and comes in the side door quite often, too. He is not bashful.

I notice you made the observation that you did not want to pass judgment on the reconsideration level. I would like to have your comments on that. I am sure that you, as former head of the disability examining program, have studied and worried and concerned yourself about the reconsideration level. It is not anything new. We are trying to move it up or leave it like it is. We would like your comments as soon as you could get them to us.

We appreciate your testimony, all of you. What you have said has been very helpful to us, and we thank you very much.

Now, the Chair would ask Mr. Rudolph Patterson, Mr. Richard Gibson, and Jane Yohalem to come forward, if you are here, please, and take your places at the witness table.

Mr. Patterson, I started to say in the center, but that would be obvious.

Mr. GIBSON. I am Mr. Gibson in the center.

Ms. SHOR. Mr. Patterson was unable to be here this morning, and I would ask to testify in his stead.

Chairman PICKLE. You are?

Ms. SHOR. Nancy Shor.

Chairman PICKLE. Mr. Patterson was representing the National Organization of Social Security Claimants' Representatives, and I assume you represent the same group.

Ms. SHOR. Yes, sir.

Chairman PICKLE. And Mr. Richard Gibson represents the People United For Self-Help, and Jane Yohalem is staff attorney for the Mental Health Law Project.

Do you all have individual statements?

Mr. GIBSON. Yes, Your Honor, we each probably have a different item to address.

Chairman PICKLE. Each of your statements will be included in its entirety in the record of the hearing. We will ask you to proceed. How would you like to proceed, in the order at the table? Ms. Shor? Do you have any preference? We will yield to the lady first, Nancy Shor. Would you proceed?

STATEMENT OF NANCY G. SHOR, EXECUTIVE DIRECTOR, NATIONAL ORGANIZATION OF SOCIAL SECURITY CLAIMANTS' REPRESENTATIVES

Ms. SHOR. Thank you. Mr. Chairman Pickle and members of the subcommittee, my name is Nancy Shor. I am executive director of the National Organization of Social Security Claimants' Representatives. Ours is a national association of attorneys and other claimant's representatives from both the private bar and legal services. We represent claimants for social security benefits.

I have served in this capacity since the inception of NOSSCR almost 3 years ago, and in that time, I have worked closely with the NOSSCR members and with individuals within the Social Security Administration, gaining a perspective helpful in analyzing the workings of the social security disability system and in developing ideas for the improvement of this important process. Before assuming my current position, I worked for 3 years in a private law firm where I represented disability claimants.

I thank you, Mr. Chairman and members of the subcommittee, for allowing me to discuss with you today H.R. 5700. I want to applaud your efforts in addressing the impact of the continuing disability investigation or CDI process, which Congress last year instituted, and which the administration drastically accelerated last March.

As a result of this acceleration, members of this subcommittee and many, if not most, of your colleagues in this Congress have been inundated by inquiries from constituents who have been recipients of disability benefits, but who now find that, because of a termination decision on their case, they have been removed from the rolls. In most cases, they are losing the only available income source.

Last week, this subcommittee continued hearings on another crucial area in the disability evaluation system, that of volume providers and consultative examinations. Both the subject of that hearing and the subject of this hearing today, the decisionmaking process of the social security disability program, are complex questions that demand careful study.

Our aim, like yours, is to arrive at a system of disability determination that will provide a high degree of accuracy, that will be efficient and cost effective.

Today, we will suggest ideas which we feel would provide a high degree of accuracy, with a heightened awareness of efficiency and expense. Justice can be efficient. Let's be clear that cost is measured not only in balance sheets in Baltimore, but is also reflected in homes across the country of social security applicants and recipients.

I will not at this time echo many of the instances that we have heard referred to earlier and which I am sure have been filling congressional mailboxes concerning this program, but I wanted to call this to your attention. Because there is so much substance in this bill, and because it touches so many phases of the disability determination system, we will concentrate on only a few points on which we hope to contribute to your analysis.

The first item was referred to as an enhanced role of reconsideration. In reality, this is a major restructuring of the social security disability determination system. I think most will agree that the second stage of the process—that is, reconsideration—is quite universally acknowledged as of little value in the evaluation process as a whole. As it exists today, reconsideration usually serves no more than as a rubberstamp for the denial made at the initial level. This is due in no small part to several factors, including that it follows closely on the heels of the initial denial, and is usually based on virtually the same evidence, and is made by employees of the same agency which has already denied the claim.

In your March 3, 1982, statement introducing the bill, you pointed out that the rate of affirmance of reconsideration of initial denials has steadily risen to an alltime high of 87 percent. The reconsideration stage as it exists now is not very helpful in the adjudication of disability claims and is far from cost effective.

We are therefore confronted with only two choices for the reform of the reconsideration stage. This bill chooses the option of, in quotes, "beefing up reconsideration with the intention of revitalizing it."

For years your subcommittee has heard testimony that the reconsideration phase in the adjudication process is not fulfilling its function, and the proposal found in H.R. 5700 is an attempt to correct that deficiency.

Just to summarize, in termination cases the bill would beef up reconsideration by providing a hearing conducted by non-Administrative Procedures Act hearing examiner, as well as by closing the record for the recipient of medical evidence.

In cases involving initial entitlement, the bill would beef up reconsideration by extending the time in which a claimant may submit evidence from 60 days to 6 months on his appeal, and again closes the record for the receipt of further medical evidence. Let us examine these beefing up of reconsiderations for both terminations and initial entitlements. Our standard for evaluation is whether or not they promote the administration of efficient justice.

First, I would like to address the termination cases. We share your deep concern over the situation that has arisen in many cases. We support the concept of continuing payment of benefits through the hearing decision, as reflected in the bill.

Where we differ from the bill is where the hearing should be conducted and by whom. The Social Security Administration already has a hearing system. Recognizing the necessity for speedy adjudication of SSI termination cases, Congress directed that the Social Security Administration expedite the resolution of those cases by eliminating reconsideration.

This means SSI recipients who have been terminated appeal directly from the initial denial to an ALJ hearing. SSI beneficiaries who have been terminated at the initial stage are entitled to the payment of interim benefits through the ALJ's issuance of a decision. This procedure recognizes the twofold importance of preserving the only financial support the average individual SSI recipient has while at the same time limiting the period of time payments might be made to an ineligible individual.

We recommend for title II termination cases that the title XVI process be adopted. Generally, title II disability recipients, and certainly those that have been on the rolls for any period of time, have no other source of income other than the disability benefits. We question, however, the value of duplicating the existing hearing structure by setting up a new hearing bureaucracy at the reconsideration level. The Social Security Administration has already invested substantial resources in developing and maintaining the hearing structure at the Office of Hearings and Appeals.

What this bill contemplates is duplicating that structure and by implication investing comparable amounts of time, money, and resources in developing a similar hearing structure at the reconsideration level. What is most significant from the claimant's point of view and from ours is that at the proposed hearings, individuals who are employees of the same State agency which has already rendered a decision to terminate and who are not covered by the Administrative Procedures Act will be making the decisions. This means these hearings cannot provide full due process. The creation of this new layer of bureaucracy does not place us any closer to the administration of efficient justice.

Our recommendation, in summary, is that a title II beneficiary who has received a termination decision on his or her case and who wishes to appeal be permitted to file a request for hearing before an administrative law judge. That is, a hearing carrying with it full due process.

Our recommendation is that careful consideration be given to the elimination of reconsideration in this stage, as well. We are not satisfied by claims that the reconsideration process fulfills a funneling function in limiting the number of cases that arrive at the ALJ level. The proposal to beef up reconsideration by closing the record is a step in the wrong direction.

The average title II claimant is not well schooled, does not have a high level of educational attainment. Claimants rely on their government, and in this case the Social Security Administration, to develop the medical evidence, as it is reasonable to assume that the Agency will since it requires such detailed information on the application form concerning medical history and providers of medical care.

The claimants may well not discover until after the reconsideration denial that the State agency examination chose not to seek certain medical evidence, and may have consulted a treating physician only by telephone contact with that physician or his or her nurse, or may not have pursued certain evidence at all.

Under this proposal the claimant would not be able to gather this evidence or have his representative gather it for submission to an ALJ. In addition, many claimants suffer from degenerative conditions that are day to day becoming worse. Others are suffering from difficult-to-diagnose conditions, or have mental impairments of which they are not aware. These may often not be recognized until after the reconsideration denial.

Under this proposal, this evidence could not be submitted to an ALJ. The purpose of the entire disability determination process is to determine in the most efficient yet accurate manner possible whether a claimant is or is not disabled. To promote these goals, the most effective means of insuring efficient justice is to allow the ALJ's to continue to render decisions based on all relevant and material evidence.

This bill creates an artificial barrier to the submission of relevant evidence by a system of remands to the State agencies, which in all likelihood would be filed by appeals back to the ALJ's. Efficient justice would not be served. The cost of this beefed up reconsideration would be increased, and claimants would find themselves bandied about between the ALJ's and the State agencies.

The second item I would like to address is that of attorneys' fees. The bill contains the administration's budget recommendations relating to attorney fee provisions under the Social Security Act.

As you know, under current law the Secretary has the responsibility for setting reasonable fees, and for paying authorized fees out of the 25 percent withheld portion of the claimant's past-due benefits. These fee provisions were originally enacted to regulate the amount of fees to insure the availability of representation and, at the same time, to prevent excess fee charges.

The administration is now seeking deregulation of attorneys' fees, but it is deregulation with a twist. The proposal would remove the both fee petitioning system wherein the ALJ or other administrative personnel actually set fees, and replace it with open authority for the Secretary to promulgate regulations which would prescribe the maximum fee.

I think it may be of interest that the Veterans' Administration system functions under a maximum fee of $10. I need not point out the impact of this on representation.

The proposal would also eliminate the Secretary's current responsibility to withhold 25 percent of past-due benefits and to certify so much of it would be authorized as a fee directly to the attorney. We believe that adequate representation is an important service for disability claimants and an important element in the Social Security Administration system of disability determination.

Mr. Shannon asked earlier whether or not Senator Riegle was aware of constituents who contacted his office who were being terminated who in fact were not disabled. Certainly people are being terminated who are no longer eligible for benefits.

When these individuals contact an attorney for representation, you have an attorney who is operating on a contingency fee basis. That attorney is very likely not to take the case, and to so advise the individual that his claim is not meritorious. We think this is an indication that representation can be a real service to the administration of this program.

For adequate representation to continue by the private bar, compensation is a vital issue which must be addressed. We are aware that the capacity of many legal aid offices which in the past represented many disability claimants is now curtailed severely by budget restrictions. It is therefore important to produce legislation which will enable private attorneys to receive reasonable compensation for services rendered while representing these claimants.

The administration's proposal is not one of complete deregulation of the amount of fees, because it reserves to the Secretary the authority to set maximum fees. If fees are to be limited to a ceiling, we believe that should be decided by Congress and not by the Social Security Administration. We must find a balance between fees which will enable attorneys to represent these claimants, and fees which are excessive.

We have two recommendations, depending on whether we are talking about an initial entitlement case or a termination case. We recommend in initial entitlement cases that the present fee structure be modified less drastically. In view of the administrative time and expense involved in reviewing fee petitions and determining fees, the elimination of that process is reasonable.

In its place we recommend that in every initial entitlement case, the fee is automatically set at 25 percent of past-due benefits. In view of the administrative time and expense involved in certifying authorized fees out of withheld past-due benefits, it is reasonable to eliminate the unnecessary complexities of that process.

In its place we recommend that 25 percent of the past-due benefits automatically be sent to the attorney of record at the same time that the other 75 percent is paid to the claimant. Such an automatic system would be highly efficient. In termination cases we have to modify this slightly in light of our previous recommendation that interim benefits be paid until the issuance of an ALJ decision.

There would therefore be no past-due benefits accruing. Special attorney fee provisions are needed in this area to insure the availability of adequate representation, since representation is equally valuable to this group of recipients as it is to those claimants seeking initial entitlement.

Our recommendation is that: At the successful conclusion of a termination case, a fee agreement executed by the claimant and the attorney would be filed with the Social Security Administration. This agreement would reflect the amount of the fee agreed upon. The Social Security Administration would pay that fee in full automatically through an overpayment on the beneficiary's account This overpayment would be handled by a reduction in the monthly future benefits until satisfied.

In this way, these claimants could obtain representation, which is often so desperately needed, while receiving interim benefits which are also so desperately needed.

The third issue is that of uniformity in decisionmaking. A complicated process, as best we can tell, appears to be underway at the Office of Hearings and Appeals to reorganize the State agency manual known as POMS, the OHA handbook, and the Social Security rulings. The goal is to make uniform the standards for adjudication at all levels.

Since the ALJ's conduct hearings, examine claimants and witnesses, make findings of credibility, consider all relevant evidence, make findings concerning pain, and findings concerning residual functioning capacity, and consult vocational experts and medical advisers and evaluate legal argument, their decisions may well differ from those of the State agency examiners who perform none of the illustrative list above.

It should be clear that since the procedures of an ALJ hearing and the State agency determination are so different, the final decisions are often not the same. Uniform standards will not change this. Our recommendation in this area is very straightforward.

If the agency's decision is to incorporate these various types of policy statements, then that should be accomplished through the formal rulemaking process. This would insure public comment in the formative stage, and public access to the final regulation. It would eliminate the complicated hierarchy of priority of the regulations, Social Security, and the POM's as set out in the bill.

Fourth, I would like to address own-motion review. The Disability Amendments of 1980 directed the Secretary to implement a program of own-motion review of ALJ decisions, and report on the process of their program for January 1982. The bill now under consideration sets requirements of 15-percent claimant ALJ decisions be reviewed in 1982, and increase to 35 percent at the beginning of fiscal 1983.

The purpose of any own-motion review should be the neutral one of reviewing ALJ decisions for accuracy. The method that the agency has instituted is not neutral. Only the ALJ's with the highest reversal rates, or only their claimant-favorable decisions, are under scrutiny. Why do we not have a random sample of all ALJ's, and of both claimant-favorable and claimant-unfavorable decisions?

Until a complete study is made, no one can state with assurance whether there are errors, and if there are where they are being made, and with what frequency they occur.

We recommend that any provision directing the Social Security Administration to undertake own-motion review be distributed fairly, that is, to a random selection of ALJ's, and to both affirmances and reversals. On this point I would echo the statement the Commissioner made at the beginning of the hearing today concerning preeffectuation review of the concern that, by reviewing only claimant-favorable decisions you are injecting a very unnecessary bias into the system.

We would point out that since own-motion review is being reinstituted only recently, many of the cases in which the ALJ made an award which was reversed by the Appeals Council are just now reaching the Federal courts on appeal. Only when the results of those appeals come in will there be a complete picture of the complete efficacy of own-motion review.

Mr. Chairman and members of the subcommittee, this bill is broad in its scope. I have not attempted to address herein all the issues raised because of the complexity and the number of matters covered. We would respectfully request that the record be kept open past March 31 for the receipt of written statements from others, and that this committee conduct further hearings specifically on the subject of closing the record at reconsideration before taking further action.

I would mention that there are many provisions certainly within the bill that are absolutely deserving of support, and would be pleased to see action on those quickly. I appreciate very much the opportunity to appear today, and would be pleased to answer any questions you may have.

Chairman **Pickle**. We thank you, Ms. Shor. I appreciate your testimony. You have not only raised some questions, but you have also offered your recommendations and your positions on them. We are very mindful of your testimony and the positions your group has taken.

Rather than ask you questions at this point, I would proceed with Mr. Gibson and complete the panel discussion first.

STATEMENT OF RICHARD A. GIBSON, ESQ., CHAIRMAN, PEOPLE UNITED FOR SELF HELP, INC.

Mr. **Gibson**. Your Honor, I am a private attorney. I guess you might say that I work basically out in the trenches. I can tell you what is happening on the litigation level, and how the process is working at the present time.

You are looking at a process at the present time which is creeking along just one step above collapse. The process at the present time is very cumbersome. What is needed is a good, clean-cut overhaul of the whole system. I have proposed in my presentation that you have a good, firm, initial determination step. After that step, you cut the reconsideration step totally out of the picture as just a rubberstamp waste of time.

I talked to the director of our State agency, and I says, "Truthfully, what is the purpose that you have for the reconsideration step?"

He says: "All that is is a step which we hope to funnel out a certain number of people and they will not request a hearing. They give up and quit there."

I said: "Well, do you have any idea whether that is the people that you really want to get out of the program? Or is that just the ones that quit? The ones that are mentally retarded, that have emotional problems, or that are just too sick to carry on the fight? Are not a lot of those people dropping out? And are not those the people that should actually be carrying on to the next step, not just some of the more healthy, litigious ones who are going to go on regardless of what you do?"

The reconsideration step should not just be a step put in the process to delay it. Right now the process takes about three months. One of the things that Nancy Shor did not mention is, that I generally do not get a client in my office until he has been through the first two steps. If he comes to me and I have already got a closed record on him, as an attorney what can I do for him?

The only thing I can do is start at that time to develop his case. That means: Let's go get your doctor's reports. Let's get some independent medical. Let's develop this case and get the medical evidence in the file that is needed. I have got on my desk in the office right now——

Mr. **Rousselot**. Mr. Chairman, may I interrupt just briefly? Is your statement, "Social Security Advocates?" Is that your statement? It did not have your name on it.

Mr. **Gibson**. Yes, your Honor. It is on the bottom.

Mr. **Rousselot**. Oh, on the bottom. Thank you.

Mr. GIBSON. Sorry.

Mr. ROUSSELOT. Are you giving us a summary?

Mr. GIBSON. Yes; primarily it has five or six pieces of medical evidence. That is all that is in the file. And if that case gets to the judge, the only thing that I will do is submit my evidence. The judge will then send it back down to reconsideration, and we will spend another 3 months down there before it comes back up again.

You are just developing another circular step where we will just have another 3- or 4-month delay from the time I get it to a judge, submit the evidence, and he remands it back down. That is not the kinds of things we need to speed the process up.

The main problem we have in the system right now, and the one that the bureaucracy is most concerned about, is the independent judiciary. As an attorney, and for the attorneys that I represent in Phoenix, we are very concerned that the independent judiciary be maintained. That means that you do not have quotas for them. An ALJ recently has brought court action to prevent this. He was getting too much direction on how his decisions were supposed to be made.

It allows the judge to look at the person, take testimony, and make subjective values as to how much pain he has. If you make the POM's apply to the judge, what you end up with is you are taking more and more of that objectivity away from him.

Now I asked the director of our State agency, I asked: What would be the main effect of making the POM's binding on the judge? He stated: "Well, for one thing, it would take any discretion the ALJ has away for elements of pain." Now pain is a very hard thing to determine, but there are things that can be done, psychological testing, doctors' statements as to their observations, and the underlying medical condition.

I asked him: Well, what would be an underlying medical condition which you would think would justify finding a disabling pain? He said: "Wasting of the limb, a postive ENG, or a loss of motion of the limb." Well, I said: How about a man who has had four back surgeries and the doctor says he has got significant scarring, he has got significant pain, and he puts the following limitations on the man's activities?

He said: "We do not consider that. If you do not have a shriveled limb, or an ENG showing that you have got nerve loss, then we are not going to consider pain." So when the judges consider that, they are using a different standard. I submit to you that they are using a different standard, and they are using the legally correct standard as set forth by the law, the regulation, and the court decisions.

If you allow the Administration to come in and promulgate POMs without any review process, without any legislation, then you have the Administration in fact deciding all the cases and taking the judicial power to make the decisions away from them. That is one thing that we are really against. We must have an independent judiciary if the claimant is going to get a fair break.

A few things on attorney's fees. I would go a step further. I think the Government ought to get out of attorney's fees. It is as ludicrous as me litigating a case against an insurance company that didn't want to pay anything, winning the case and then having the insurance company tell me how much I can charge the client.

If you want to have guidelines, fine; but to have the Government setting fees, withholding moneys? All you need to do is do like we do in any other type personal injury case. When the check is made out, send the first check to the client and to the attorney and let the attorney and the client work out their own fee arrangement.

There are State bar and other types of proceedings where a lawyer gets out of hand and charges excessive fees for the amount of work he does, but that would eliminate an entire level of your bureaucracy, which I really think has to be addressed and cut back down to size.

One of you gentleman asked what happens to these people. I think what has happened is very obvious. Somebody has discovered there are 20 percent too many people on the rolls and by God we are going to find those 20 percent and cut them off.

Now, who are they? Basically those people you are cutting off are people out of the workforce anyway. They are never going to return to the workforce. They are going to be back on general assistance or some other type of program. There are a few people out there which, you know, are recovered enough, people who have recovered from surgery, that type of people.

They are talking about your leaving the permanent disability definition to social security. I am handling 62-year-old men with progressive heart surgeries, and he is improving. There is no way those people are improving. I have back surgeries, three and four back surgeries. The man is getting older, his arthritis is getting worse, his pain is getting worse. He is not improving.

As I mentioned, it is really hard to explain to a fellow when he comes in and says, "I can't get this unemployment because I can't work." I said, "Well, you can't get social security because you can work. So where does that leave you. Those people are caught in the cracks. There are a lot of people out there who are not meeting the definition.

I am not saying let's extend the definition, but let's not keep contracting the definition of what gainful activity is. There are a lot who are not going to be able to return. One statistic I thought was very interesting is that about 30 percent of the people who apply get on disability; out of the other 70 percent, 50 percent never go back to work.

So it is not a question in my mind of whether you are cutting the pie too deep. I think you are probably cutting the pie too thin. The other thing, it is very disturbing to us in the field that every time I talk to anybody from the Social Security Administration they keep coming up with this we want to have more uniform decisions, more uniform decisions. It keeps boiling down to one thing: let's cut more and more people off.

That to me is not a uniform decision. Whenever you are in fact reviewing whether decisions are correct, you have to look at the judges that allow too many as well as the judges that are not allowing hardly anyone. The uniform decision should be down the middle, not on one end or the other. We are not getting that at the present time.

Now, you wanted a suggestion about what would help this process of who should be terminated. I think one good suggestion would be to require some sign of medical improvement from the doctors that treat them. I am getting reams of termination cases and I like termination cases because they are good cases. I am winning between 80 and 90 percent of them when I go to hearing because the people are being terminated without any sign of medical improvement. They are being terminated with clear, documented evidence that they are still disabled.

I took a large stack of files out to our local agency. I said, "Look at these doctors' reports, the doctors that you sent the people to. They say these people are still disabled. Why am I going to hearing on this?"

They said, "Well, they don't quite meet the listings over here and the POM's don't get us any discretion what to do with it." The face-to-face determination at recon, it was a failure in the experiment that they tried primarily because the person conducting the face-to-face had no discretion to look at the person and make any decisions on subjective evidence—sure, they are sympathetic. I have even had them say go see an attorney, I think he has got a good case, and they show up in my office after they have been told down there they think they have a good case. But they did not give them any judicial discretion in the determination. A face-to-face determination is not helpful without that.

There is another thing that is going to come up shortly. That is the advocacy procedure where you actually go to hearing and have an attorney representing the Government. That is going to be coming up in four sites pretty soon.

Two years ago we turned in reams of testimony as to why that would not work and why it would be a bad deal, but they are still going to be coming up. So that, again, is going to make it very difficult.

When you are in a hearing with a mentally retarded person—and it always interests me how a mentally retarded person improves significantly enough. I have had several IQ's in the fifties and sixties and suddenly they have improved enough to be terminated.

I would really like to handle any questions you might have as to how this program is really working in the field because I can tell you there are a lot of problems. You pass some legislation sometimes you think is going to help us, like you passed a bill last year which said that if a person is in a rehab program that is designed to return him to the work force, that person would not be terminated even though he was improving medically.

What is happening is the administration has taken a relatively good bill that was designed to help a person who had an amputated leg, and went into a rehab program to finish the program and return to the work force. As presently administered, nobody could qualify because SSA will find a medical improvement and terminate the benefits. In that bill I think you gentlemen had something entirely different in mind.

We have a case in Federal court right now to try to make the administration respond to what your law said. If a person is in an approved rehab program designed to return him to the work force, he will not be cut off while he is in that program. The information I have is that only four people have been accepted nationally. SSA wants the person not to medically improve, while the rehab people do not want a person who is not going to improve in the program.

So it is a direct contradiction of what I think your intention was and what you actually got. We would invite you to come back if at all possible or send a representative out to Phoenix so that the full group of attorneys that are working on these cases could give you our views and answer questions on how it is working.

You will have to hurry, though, because the best time to visit Phoenix is not the summertime. Don't come next summer and get a bad impression of Arizona.

Thank you for allowing me to make these comments.

[The prepared position paper follows:]

SOCIAL SECURITY ADVOCATES POSITION PAPER ON 1982 AMENDMENTS

What is needed is a thorough revision of the Social Security allowance system. The present system is slowly grinding to a halt. The number of reviews, remands, refilings, "own-motion" reviews, appeals, windfall determinations, improper workmen's compensation offsets, attorney fee determinations, reopenings, and just plain lost files boggles the mind.

A clean-cut three level system would be more workable, starting with a fair thought initial determination step. At this level, SSA should develop the case thoroughly, making a fair determination according to the regulations and law. There should be no acceptance quotas and no inherent philosophical idea that, if it is a close decision, the claim should be denied as the claimant can always request reconsideration. In fact, we feel that there should be no reconsideration level. The claimant should be told in an initial denial note of his right to appeal and informed that, if he appeals, it will be to an administrative law judge. Further, he should be told that the burden of proving his disability rests on his shoulders and that, although not required, he might be well-advised to consult an attorney of his choice for legal assistance. The hearing, also, should be conducted using the law and regulations as the basis for the decision. In the event of a second denial, the claimant should appeal directly to the Federal Court, eliminating the Appeals Council review. The Appeals Council is virtually a useless body, practicing primarily rubber stamp approval of prior determinations.

Further, the government should get out of the fee approval business. This whole area could be eliminated with one simple procedure—checks for past-due benefits on all claims could be made out to both the attorney and the claimant.

This program would eliminate three whole levels of bureaucracy—the reconsideration program, the Appeals Council, and the Attorney Fee authorization section. No one would be hurt but the bureaucrats, who do little at these levels except issue conflicting notices, lose files, rubber stamp prior actions and create delays.

The arguments for the reconsideration step are poorly reasoned. The only real reason for this step is to screen out applications in the hope that claimants will not proceed to the hearing level. Only an average one case in five is reversed at this level. It is not worth the average three month delay in processing, as well as the expense involved, to maintain this level of adjudication. A fact-to-face approach was tried and failed, because the employees conducting the fact-to-face interviews had no authority to base any decision on that meeting. Further, the POMS limited this subjective evaluation to meaningless sympathy. The present screening process at reconsideration also screens out many legitimate claims. The SSA, however, is not concerned with those too emotionally distrubed, mentally retarded or ill to continue the struggle for benefits. If these claimants drop their pursuit, reconsideration has served its purpose. The government has the ability to eliminate this step completely and enlarge the hearing process to accommodate the case load.

The best level of adjudication is the hearing process. This level, however, is the one most continually under fire. Congress must protect this level of independent adjudication. Without an independent ALJ system, the disabled will have no recourse from the bureaucracy. There have been repeated attempts in the past to make inroads here by a variety of different means. One of these in the "own motion" judicial review to insure more uniform decisions. The idea that "own motion" review will in some way make the ALJ more uniform is a curel joke. The reason we feel this to be true is that only favorable decisions are being reviewed. There is no consideration of the ALJ who is depriving citizens of their rights by wrongful decisions against them. Any meaningful review would have to look at ALJs and dsecisions on both ends of the spectrum.

The idea of closing the record after reconsideration stage is also ludicrous. Most claimants don't even consult an attorney prior to the hearing level. If the record is closed before an attorney gets the case, what can he do to develop it? Nothing. If the attorney does his job well by developing the case and submitting evidence at the hearing, the cases will be remanded to the State agency for additional review. This only extends the time required to get the case back to the hearing level, by as much as three or four months. Left unclear is whether or not ALJ can even take testimony from the claimant or his doctor at the hearing level. If no testimony can be taken, the ALJ will not have the fact-to-face ability to see and judge for himself the claimant's credibility.

Our committee does not favor making the POMS binding on the ALJ. Attached is a position paper on this subject. The law and regulation are clear and sufficient for fair adjudication. The POMS can be changed without the legal protection involved in law or regulation changes. Our committee met last week with the Program Director for the Arizona State Agency, and he was asked what he felt the major effect of making the POMS binding on the ALJ would be. He stated that they would lose much of their independent judgment, especially in the area of pain. He stated that his agency did not consider pain unless there were positive medical findings, such as wasted limbs, or positive EMG findings. When asked if multiple back surgeries would be sufficient to establish medical evidence of pain, he stated that it would not unless other positive medical findings were present. If the record is closed at the reconsideration level, POMS are made law, and agency pressure is allowed to influence the ALJ. Ultimately, we will be left with an onerous system where agency adjudication will be heard at the reconsideration level by officers who are captive employees of the same agency who made the initial decision. There will be no effective, independent ALJ system, which is so curcial to the protection of claimants.

This committee must decide what the purpose of the Social Security Act is. If it is to compensate the disabled and allow them to live in dignity, then their needs must be addressed. In our meeting with the representative of the Arizona State Agency, we asked him if he felt that fraud was a major problem. He indicated that it was not. He made an interesting comment, stating that bureaucracy had been accused of not being responsive to Congress. He felt that this was not true and, in fact, felt that it over-responds to pressure. The claim that 20 percent of all disability recipients were not entitled to benefits brought much over-reaction.

The attempts to take away the ALJ's authority, review their decision, increase the termination rate on review, etc., are all part of this over-reaction. SSA is even reviving the adversary hearing experiment. It was hoped that this issue had been buried after the 1980 hearings, but efforts to increase the bureaucracy and the forces allied against the claimant keep resurfacing.

One must remember that these people do not go away if they are denied benefits. In a national TV network story on SS, an interesting statistic was announced. Approximately 30 percent of all claimants are accepted for benefits. Of the 70 percent that are denied, only half ever engage in any meaningful work again. The standards for SS disability are strict. How often have we tried to explain to a claimant that he is not entitled to unemployment benefits because he cannot work and that, at the same time, he is not entitled to SS benefits because he can work—or why the VA has found him to be 100 percent disabled, but SSA finds that he is not disabled. It is equally hard to explain to a 44 year old person with multiple back surgeries, limited education and no skills that he is not disabled, even though no employer would touch him with a ten foot pole due to industrial insurance considerations. How does one explain to the person with a history of heart disease and bypass surgery that he, too, is not disabled, even though no one will hire him due to the risk factors and the fact that he is not competitive in the labor market. These are the frauds and malingerers that make up the bulk of the 20 percent who "are not entitled to benefits." They also constitute a portion of the current terminations, now being rooted out as cheats.

This committee should get input from the grassroots. We once again invite you to come to Phoenix for hearings so that we can give you inside information on what it is like in the trenches. We are not your adversaries. We want this system to work fairly and efficiently, and our input can be helpful.

We, therefore, suggest:

1. That the ALJ's judicial integrity be maintained by eliminating pressure from the judges and that "own motion" reviews of ALJ's decision be eliminated.
2. That the law and regulations be used as the standard for disability.
3. That the reconsideration level and the Appeals Council be eliminated.

4. That the attorney fee branch be eliminated by making payment of back benefits payable to both claimant and attorney.

5. That a finding of legitimate medical improvement be required to terminate benefits in cessation cases.

6. That hearings be held to obtain information from professionals working daily in the disability area.

SOCIAL SECURITY ADVOCATES POSITION PAPER: H.R. 3207

The massive regulatory change proposed by H.R. 3207 would almost entirely destroy the due process hearing rights currently available to Social Security disability claimants. The destruction envisaged by H.R. 3207 would have the P.O.M.S.[1], a manual written by bureaucrats for other bureaucrats, become binding on Administration Law Judges' disability determinations. This would override the current criteria for disability contained in the Code of Federal Regulations which were legally adopted after publication and comment.

Now, the P.O.M.S. adjudicatory standards govern determinations made by State Disability Determination Services (and adopted by SSA District Offices) at the initial application and reconsideration levels. It is only after denial at the initial and reconsideration levels that a disability claimant is entitled to a face-to-face hearing before an Administrative Law Judge. There, the legally enacted standards for disability apply, as contained in the Code of Federal Regulations. There, a claimant is often represented by counsel and has additional evidence submitted in his favor. There, a claimant's case is often more fully developed, e.g., through use of a vocational expert or medical advisor testifying at the hearing. It is little wonder that if a claimant can survive the running of this bureaucratic gauntlet up to the hearing stage, s/he has a better than average chance to prevail on the merits of the case. Recent statistics show that while the rate of denial at the initial and reconsideration levels is increasing, the rate of favorable decisions by ALJ's (reversing those denials) is perforce also increasing, currently reaching 60% nation-wide (see attached).

The proposed statute is apparently aimed at this variance in decisionmaking. Yet, the proposed solution ignores the real nature of the problem. The proposed solution blithely assumes that state agencies are right and Administrative Law Judges are wrong. The fact of the matter is that ALJ's usually have the advantages of an informed advocate, additional evidence (either garnered from sources overlooked by the state agency or solicited by counsel with a focus on the particular legal issues involved in the claimant's case), and, most importantly, the opportunity to actually observe the claimant face-to-face while discussing the merits of the case. Here, issues of credibility and subjective complaints enter the picture. And ALJ, for example, can evaluate the debilitating effects of pain, in light of the available medical documentation, in assessing a person's ability to function. (20 CFR §§ 404.1529, 416.929.) A State agency bureaucrat, under P.O.M.S., cannot.

Some cases in point:

1. Sue D. is a 62 year old female applying for Supplemental Security Income. The consulting examiner for the state agency performed a psychiatric evaluation which resulted in a diagnosis of "organic brain syndrome such as Pick's or Alzheimer's disease." The consulting examiner stated that the "patient appears absolutely unable to function effectively in any environment. Her memory is too poor to respond to any types of regulations or rules." Yet, a DDS medical consultant who never saw, talked to, or examined the claimant found that she was not disabled! Sue's claim must now go before an Administrative Law Judge.

2. Betty C. was a 42 year old woman with a history of adult onset diabetes and amputation of the fifth matatarsal of the left foot. She carried four hundred and twenty five pounds on her five foot nine inch frame. The Social Security Administration criteria for impairments indicate that a person of that height weighing over two hundred ninety eight pounds will be considered disabled if there is evidence of particular additional impairments. Despite the fact that Betty was one hundred and twenty seven pounds over the disability criteria, the state agency found that she was not disabled. Her claim was only granted when she appeared before an Administrative Law Judge, represented by counsel who submitted additional x-ray evidence of "degenerative changes of the knee joint."

3. Dorothy D. Was a 23 year old woman with an above the knee amputation of her left leg after an accident involving an attempt to get on a moving train. The

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[1] Program operations manual system.

medical records before the state agency concerning this accident clearly contained references to "a white female who is retarded." Despite this clear evidence, the state agency did not follow through with any evaluation of the claimant's mental condition. After denial of disability by the state agency, the claimant's attorney at hearing presented evidence to the Administrative Law Judge that the claimant's I.Q. was below 70. Her claim was then ultimately granted.

4. Gene R. was a 43 year old male with a past work history of arduous physical labor. As a result of an on-the-job injury, Gene suffered a roto cuff tear to his left shoulder when he attempted to catch himself when falling from a scaffold. Under the Social Security Administration's criteria for impairments, even a complete amputation of Gene's left arm would not establish disability. However, in preparation for hearing, claimant's attorney solicited hospital records not obtained by the state agency and arranged for psychiatric and psychological consultations specifically aimed at the debilitating effects of pain and secondary depression from his injury. At the hearing, the Administrative Law Judge observed a man with a neck brace and an immobilizing device consisting of a corset to which the left arm was attached. The claimant was covered with sweat from the physical effort involved at attending this hearing, during which he broke down in uncontrollable tears at several points. Disability benefits based on the physical impairments plus two separate diagnoses of major depression, were ultimately granted by the Administrative Law Judge.

In fact, adoption of P.O.M.S. as the basis for ALJ adjudication will not establish uniformity, short of the actual establishment of a quota system for denials of disability. (Social Security Administration employees at lower levels have, indeed, admitted the existence of an informal quota system for denials of disability.) Administrative Law Judges have a variance in decisionmaking vis-a-vis the state agencies because by and large they are following their legal duty to conduct disability hearings "in an impartial manner." (Administrative Procedure Act, 5 U.S.C.S. § 556(b).) Rather than attacking the problem where the difficulties actually arise—at the state agency levels—H.R. 3207 is but a thinly veiled attempt to eliminate the present system of individualized disability determinations. In fact, H.R. 3207 is an attempt to change the judge into the holder of a rubber stamp for ratification of disability denials. Until we decide to abolish support for our disabled people, we should operate the system on a fair, individualized basis.

THIS REPORT PREPARED BY SOCIAL SECURITY ADVOCATES

The foregoing proposals for change in the 1982 disability amendments are the product of members of a volunteer group in Phoenix, Arizona, known as Social Security Advocates. The Advocates group is comprised of concerned individuals actively involved with Social Security's Disability Insurance and Supplemental Security Income Programs. The group's formation several years ago was spearheaded by the professional staff of People United For Self Help (P.U.S.H.). P.U.S.H. is the only social service agency of its kind in the Country, with an entire unit of social workers and support personnel specializing in disability evaluation. Since the unit's inception in 1974, P.U.S.H. has served more than 2,300 claimants who had been denied disability benefits and/or supplemental security income at least once.

Some members are attorneys and paralegals in private practice or with Community Legal Services, who regularly represent claimants before the Social Security Administration and in Federal District Court. Their combined experience approaches 3,000 cases. Other members include State vocational rehabilitation counsellors, staff from several Arizona congressional offices and representatives of Social Security at the administrative levels and from the Office of Hearings and Appeals. A number of university professors belong, who have done analytical studies of Social Security systems operations.

Organizations who deal primarily with the disabled are also represented. Examples of these groups are the Association for Retarded Citizens and the Arizona Department of Economic Security Aging and Adult Administration.

Together, Social Security Advocates feel they have an unusually insightful grasp of the workings of the Social Security Disability and Supplemental Security Income systems. If you have any questions on any of the material contained in the position papers or wish to discuss other issues, please feel free to contact the Advocates' chairman, Richard A. Gibson, Jerome & Gibson, P.C., 710 Luhrs Building, 11 West Jefferson Street, Phoenix, Arizona 85003, (602) 254-8481.

Chairman PICKLE. Thank you, Mr. Gibson.

I am surprised to hear that only four people nationwide have been helped in this particular instance. The staff tells me that is not correct, that there were 25.

Mr. GIBSON. Twenty-five. It improves.

Mr. ROUSSELOT. Are you going to follow up on his invitation to Phoenix for this summer? [Laughter.]

It is on the way to California, if you would like.

Chairman PICKLE. I would say to you, Mr. Rousselot, "By the time you get to Phoenix * * *" [Laughter.]

Ms. Yohalem, do you have a written statement?

Ms. YOHALEM. Yes, I have.

Chairman PICKLE. Can you condense your statement? I see you have a volume here. You are a volume provider. [Laughter.]

How are you going to handle this?

Ms. YOHALEM. I am going to summarize my statement. The second document you have there is a report that is being submitted only for the record.

Chairman PICKLE. Your entire statement will be included.

Mr. ROUSSELOT. It is only five pages.

Chairman PICKLE. I see it now.

STATEMENT OF JANE YOHALEM, STAFF ATTORNEY, MENTAL HEALTH LAW PROJECT

Ms. YOHALEM. My name is Jane Yohalem and I am a staff attorney at the Mental Health Law Project. The project is a nonprofit public interest organization that advocates for the legal rights of disabled persons, particularly the mentally ill and the developmentally disabled. On behalf of the project, I appreciate this opportunity to comment on H.R. 5700, the Disability Amendments of 1982.

I want to express the mental health law project's view about the effects of the accelerated review which began in March 1981 of the claims of people who depend on disability insurance and on SSI.

During the past year we have received increasing numbers of calls and letters from disabled people and from lawyers and treatment professionals around the country who represent disabled people. Case after case has been either sent to us or called into us describing truly disabled people, people who obviously meet the requirements of the social security disability law and regulations and who yet are being dropped from the rolls.

The human cost of this is staggering. People have lost their homes, people had to drop out of essential treatment programs, others have ended up on State or county funded relief if they are lucky enough to be in a State or county that has a relief program.

The effect on the mentally disabled has perhaps been the most extreme of all. Many mentally ill people, unable to withstand the stress of having their benefits terminated, end up with their illness worsening and need to be rehospitalized. Inpatient psychiatric care at a State or county hospital costs the States and county governments large amounts of money, far more than it would cost to keep these people on the disability rolls.

In addition to these individual case examples, a look at the statistics nationwide reveals a problem that is national in scope. A Social Security Administration study cited by GAO in its March

1981 report found that 11 percent of a sample of undiaried recipients could be expected to be ineligible. If diaried persons—persons expected to recover—were included in that sample, the figure rose to 20 percent.

However, in the continuing disability investigations nationwide, over 45-percent of reviewed recipients are being dropped from the disability rolls by the Social Security Administration. In New York State the termination rate is over 50 percent, in New Mexico it is 70 percent. Something is wrong here.

Chairman PICKLE. Excuse me just a minute. I am trying to get the figure on nationwide. I am told there might be 40 to 45 percent. Proceed. Pardon me.

Ms. YOHALEM. Nationwide 45 percent is the figure I have.

Chairman PICKLE. It is 40 to 45 percent, apparently, but this is of those numbers who are being initially brought in first, the first run of them, those who apparently the computer says look at this person. We do not know whether that percentage will remain the same, but at least that is a reasonable agreement of the figures.

Ms. YOHALEM. My understanding was the 45-percent figure was at the State agency level. It is before the case gets to the ALJ level.

Together with the save our security coalition and 11 national organizations representing disabled people, the project has prepared a report which analyzes the practices which are leading to the arbitrary and illegal cut-offs of disabled people who cannot work and who desperately need these benefits. The report includes 29 individual case examples from 14 different States.

Let me just say these are not isolated examples. These are typical of hundreds that have come to our attention. The report is the second statement that is attached for the record.

The practices which we have found are occurring across the country include perfunctory reviews of cases. For many people the termination notice is the first notice they receive. Often they are not asked to submit additional information. Often also the treating physician is not notified and necessary medical information is not obtained from him.

Second, we find examples of people relying on inadequate medical evidence. Examinations by consulting physicians lasting 10 minutes or less are not uncommon. In addition, the use of volume providers is occurring in increasing numbers in order to be able to handle the sheer number of cases being reviewed.

Third, we see use of criteria which are irrelevant to employability. Mentally disabled seem particularly severely affected by this problem. "Someone able to dress himself must be able to work," seems to be the simplistic approach being taken toward the mentally disabled.

Fourth, we see review and appeal procedures simply being beyond the capacity of many mentally disabled people, and those people end up getting cut off the rolls simply because they are not able to adequately develop their own file and pursue their appeal.

Mentally disabled people, like other people, receive a complicated three-page form. Many are just too disoriented because of their illness to fill out that form adequately and to present sufficient evidence of their continuing disability. If they do make it through the phase of filling out the form, they are still terminated because not enough information is provided. The appeals process, as you all know, is even more difficult and confusing. With cutbacks in legal services and other advocacy programs around the country, fewer people are able to obtain representation even if they are capable of asking for it.

Let me give you just two examples from the many cited in the coalition's report of some truly disabled people, clearly eligible, who were cut off the rolls. The names I will use are fictitious in order to protect the privacy of these persons, but they are real case examples.

William Powell is an ex-military policeman from Georgia. He is partially paralyzed due to a shotgun wound which also affects his vision and his memory. Mr. Powell was sent to see a consultant physician who spent 10 minutes with him and did not ask him to undress for that examination. The doctor's report makes no mention of extensive atrophy of Mr. Powell's arm and leg muscles, which would have been visible had his clothes been removed for the examination, yet Mr. Powell's benefits were terminated based on this examination.

William Thomas of Tennessee is mentally ill. He received a three-page form from Social Security informing him that his case was being reviewed and he should fill out the form and send it back. He failed to complete the form and instead wrote disturbed notes in the margins. Eight months later he received a notice that he was being retroactively terminated from the rolls for failure to fill in the form. He is now in a State institution in Tennessee.

These arbitrary and illegal terminations are disrupting people's lives, yet in many ways the fact that they are happening is not surprising. Social Security agency officials are under tremendous pressure to save money by reducing the disability rolls. They are snowed under by the sheer volume of cases being sent to them. The number has doubled this year.

They expect to review 520,000 cases. They have not had adequate time to gear up for this accelerated review process. Moreover, not enough new staff have been hired to handle the increased volume.

H.R. 5700 offers some provisions that will help severely disabled people. For example, extending benefits to title 2 recipients pending appeal will help limit the hardship now faced by those who are ultimately reinstated when their case reaches an administrative law judge.

However, H.R. 5700 does not address the heart of the problem, the massive numbers of unjustified and illegal terminations occurring throughout the country. Many of its provisions, if passed, could in fact aggravate the injustice. Take, for example, the provision eliminating evidentiary hearings before administrative law judges. The current rate of reversal by administrative law judges is high because so many errors are being made at the agency level.

Turning greater responsibility for the appeals process over to the agencies that are making those errors will simply compound the problem. In our view, neutral, independent hearing officers are essential to insure that the law is followed. Allowing reliance on the program operations manual system, the POMS, will aggravate the existing problem of Social Security officials basing terminations on criteria inconsistent with the law and regulations.

Certainly uniformity of decisionmaking criteria is important, but the criteria used by the decisionmakers at all levels should be those set out in the law and the regulations. Use of informal criteria like the POMS, which are not subject to public comment and review, increases the probability of error.

Another provision, the closing of the evidentiary record after reconsideration is complete, would impose a burden on the majority of disabled people who do not ordinarily seek legal help at this stage with the process. By increasing the burden on the beneficiary to prepare an adequate record, this provision will aggravate the difficulties that already confront those least able to represent themselves, the mentally disabled.

Other mandates of H.R. 5700, like the 4-month adjustment period, the vocational rehabilitation program and the limitation on recovering overpayments are laudable provisions that will help cushion the loss of benefits for people who have, in fact, recovered and are able with some assistance to return to work, but these provisions will not solve the problems I have just identified.

The truly disabled people who have been wrongfully terminated from the rolls are not capable of returning to work even with a vocational rehabilitation program. Four months of additional benefits can do little but postpone the inevitable crisis.

I urge the committee to schedule oversight hearings so that it can explore in depth the problems faced by people caught up in the continuing disability review process before it amends the law governing that process. Following these hearings, legislation or other action can be formulated to remedy the problems that are uncovered.

I would like to conclude by again thanking the subcommittee for this opportunity to present our views, and I will be glad to answer any questions.

[The prepared statement follows:]

STATEMENT OF JANE BLOOM YOHALEM, STAFF ATTORNEY, MENTAL HEALTH LAW PROJECT

My name is Jane Yohalem and I am a staff attorney at the Mental Health Law Project. The Project is not a not-for-profit public-interest organization that advocates for the legal rights of disabled persons, particularly the mentally ill and the developmentally disabled. On behalf of the Project, I appreciate this opportunity to comment on H.R. 5700, the Disability Amendments of 1982.

The Project is concerned about the effects of an accelerated review which began in March 1981, of the claims of people who depend on Disability Insurance and SSI. During the past year, we have received calls and letters from disabled people throughout the country whose Social Security disability benefits were abruptly terminated. Lawyers and treatment professionals have come to us also, describing case after case of clients with severe mental and physical disabilities who nevertheless lost their essential Social Security benefits.

We quickly realized that this was a nationwide problem—that throughout the country truly disabled people who meet the requirements of Social Security law and its regulations are simply being dropped from the rolls. People who are unable to do work of any sort are left without any income. Some have lost their homes; others have had to withdraw from needed treatment programs. Many end up on state- or county-funded general relief programs (in states where those exist). The mentally ill are the hardest hit. The stress of losing their benefits often triggers a crisis in their illness, which in turn leads to hospitalization, at much greater cost to the taxpayer than the amount of the lost benefits. The press has reported several suicides.

A look at the statistics also reveals a nationwide problem. A Social Security Administration study cited by GAO in its March 1981 report found that 11 percent of a sample undiaried recipients could be expected to be ineligible. If diaried persons (those scheduled for later review) were included in the sample, the figure rose to 20 percent. However, in the continuing disability investigations, nationwide over 45 percent of reviewed recipients are being dropped from the disability rolls, according to the Social Security Administration. In New York State, the termination rate is over 50 percent; in New Mexico, it is 70 percent. Something is wrong.

Together with the Save Our Security Coalition and 11 national organizations representing disabled people, the Mental Health Law Project analyzed the practices that have led these to arbitrary cutoffs and prepared a short report, which I have submitted to the Subcommittee for its record of these hearings. The report summarizes 29 cases from 14 states. These examples of people wrongfully denied benefits typify the hundreds of cases that have come to the attention of the Mental Health Law Project, the Save Our Security Coalition and the other organizations endorsing the report.

The case examples illustrate several kinds of practices by both state and federal Social Security officials which have cut eligible people off the disability rolls, contrary to the provisions of the Social Security law.

These practices include:

Perfunctory review: In many cases, the first word a recipient receives of a review is a termination notice. Often, the person's treating physician is not contacted.

Another common failing is relying upon inadequate medical evidence. Examinations by consultant physicians often last less than 10 minutes. To deal with the flood of case reviews, Social Security officials are relying more and more on volume medical providers.

Often review and appeal procedures are beyond the capacity of mentally disabled people. Mentally disabled persons often neglect to return the Social Security forms or complete them inadequately. Then, as a direct result of their disabilities, they lose their only support.

Reviewing officials also base terminations on criteria irrelevant to employability. Mentally disabled people are particularly vulnerable to being dropped from the disability rolls by Social Security officials who conclude that because the client can dress himself or understand simple instructions, he must be able to work.

These practices create tremendous hardship for disabled people. Take, for example, the case of William Powell, an ex-military policeman from Georgia who is partially paralyzed from a gunshot wound that also affected his vision and his memory. (His name and the names of other disabled people I will describe are fictitious, to protect their privacy.) Mr. Powell was not even asked to undress during the 10-minute medical examination that led to termination of his benefits. Yet his clothing hid extensive atrophy of his arm and leg muscles, which would have clearly documented his total disability.

William Thomas of Tennessee, who is mentally ill, received a standard form asking about his illness and treatment. He scrawled disturbed notes in the margin and sent it back. Eight months later Mr. Thomas' benefits were discontinued—retroactively, with a demand for repayment—because of his "failure to complete" the Social Security form. Mr. Thomas is not institutionalized at Moccasin Bend State Hospital.

While such arbitrary and improper terminations are egregious, they are not surprising. Social Security officials in state agencies are under tremendous pressure to save money by reducing disability rolls. Moreover, the number of reviews they are required to complete has more than doubled—520,000 cases this year, nationwide. State agencies have not had time to gear up; they have not hired nearly enough staff to handle the increased workload.

H.R. 5700 offers some provisions that will help severly disabled people. For example, extending benefits to Title II recipients pending appeal will help limit the hardship now faced by those who are ultimately reinstated when their case reaches an administrative law judge.

However, H.R. 5700 does not address the heart fo the problem—the massive numbers of unjustified and illegal terminations occurring throughout the country. Many of its provisions, if passed, could in fact aggravate the injustice. Take, for example, the provision eliminating evidentiary hearings before administrative law judges. The current rate of reversal by administrative law judges is high because so many errors are being made at the agency level. Turning greater responsibility for the appeals process over to the agencies that are making those errors will simply compound the problem. In our view, neutral, independent hearing officers are essential to insure that the law is followed.

Allowing reliance on the Program Operations Manual System (POMS) will aggravate the existing problem of Social Security officials' basing terminations on criteria inconsistent with the law and regulations. Certainly uniformity of decisionmaking criteria is important, but the criteria used by decisionmakers at all levels should be those set out in the law and the regulations. The use of informal criteria like the POMS, which are not subject to public comment and review, increases the probability of error.

Another provision, the closing of the evidentiary record after reconsideration is complete, would impose a burden on the majority of disabled people, who do not ordinarily seek legal help at this stage of the process. By increasing the burden on the beneficiary to prepare an adequate record, this provision will aggravate the difficulties that already confront those least able to represent themselves—the mentally disabled.

Other mandates of H.R. 5700, like the four-month adjustment period, the vocational rehabilitation program and the limitation on recovering overpayments are laudable provisions that will help cushion loss of benefits for people who have in fact recovered and are able to return to work. But these provisions will not solve the problems I have just identified. The truly disabled people who have been wrongfully terminated from the rolls are not capable of returning to work, even with a vocational rehabilitation program. Four months of additional benefits can do little but postpone the inevitable crisis.

I urge the committee to schedule oversight hearings so that it can explore in depth the problems faced by people caught up in the continuing disability review process before it amends the law governing that process. Following these hearings, legislation or other action can be formulated to remedy the problems that are uncovered.

I would like to conclude by thanking the subcommittee for this opportunity to present our views.

ARBITRARY REDUCTIONS OF DISABILITY ROLLS

Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) provide essential support to 4.5 million Americans who are so severely disabled that they cannot work.[1]

In March 1981, the Social Security Administration (SSA) began an accelerated review of the claims of people receiving these benefits. In an excess of fervor to reduce federal expenditures, Reagan Administration officials have created a process that is illegally leaving thousands of severely disabled Americans without any source of income for food and housing. Many are then relegated to the wards of public mental institutions or to dependency on county and state relief rolls.

Periodic review of disability cases is necessary, of course, to confirm that recipients continue to meet eligibility requirements and remain unable to work. However, the undersigned organizations contend that the Administration's current approach is contrary to both the letter and the spirit of the careful review that was mandated by Congress in the Social Security Disability Amendments of 1980.

In fiscal year 1982, 520,000 recipients of disability benefits will undergo review, compared to 400,000 in fiscal year 1981 and 200,000 in fiscal year 1980. The Administration plans to save $200 million in 1982 by drastic reductions in disability rolls based upon these reviews.[2] State agencies, charged with the initial reviews, are under tremendous pressure, without adequate time to gear up and without enough staff to handle the increased load. As a result, reviews are often perfunctory, without adequate medical evidence and with insufficient attention to individual problems, as documented by the attached case examples.

These difficulties are compounded by pressure on administrative law judges and on Social Security personnel to quickly produce a substantial reduction in disability rolls consistent with Reagan Administration policy. For example, SSA has targeted for review the 65 administrative law judges who have the highest rate of findings that continue disability benefits. Only findings in favor of beneficiaries are being reviewed, not decisions terminating benefits.[3] Similarly, SSA is routinely reviewing 35 percent of decisions of state agency personnel in favor of beneficiaries, while only 5 to 7 percent of benefit terminations are reviewed.[4]

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[1] In addition, 1 million children and 500,000 spouses receive SSDI as dependents. Monthly payments to SSDI recipients average $413.57; SSI recipients receive $264.70.

[2] Social Security Administration, "Improvement of the Administration of the Disability Program—Continuing Disability Investigations" (CDI); Mar. 11, 1981.

[3] Jan. 7, 1982, memorandum from Louis B. Hays, Associate Commissioner of Office of Hearings and Appeals, SSA, to all Administrative Law Judges (Jan. 7, 1982, memorandum).

[4] Interview with Jean Hinckley, General Counsel's Office, SSA.

The review procedures are especially unfair to the mentally disabled. When a case is under review, the state agency mails the disability recipient a three-page form seeking detailed information about his or her medical condition and employability. If this form is not completed and returned within 35 days after being mailed, benefits are often terminated. The Mental Health Law Project, a Washington D.C.-based public-interest organization, has received reports from states across the country that, without help, many mentally disabled clients have trouble coping with the paperwork. Many are unable to understand that their only income is being threatended. They neglect to return the forms or complete them inadequately and, as a direct result of their disabilities, lose their monthly support. The problem is compounded by the SSA's practice of conducting these reviews without a face-to-face interview.

Although denial of disability benefits can be appealed, the appeals process does not adequately protect disabled Americans and their families. First, Social Security Disability Insurance recipients lose all benefit shortly after receiving a termination notice—including Medicare, to which they are entitled after two years of disability.[5] During the time their appeal is pending, which can be five months to a year, they receive no benefits.[6] Even if benefits are then reinstated—and that often takes several months after a favorable decision—many severely disabled people will have already lost their homes or will have been forced to discontinue residential or treatment programs.

Moreover, an appeal requires presentation of medical and other evidence before the appropriate agency or before an administrative law judge or a court. Cutbacks in legal services and social service agencies have made it very difficult for disability recipients to obtain legal or other help. Again, the difficulties are multiplied for mentally disabled recipients, who may not know where to turn for assistance and who, because of their chronic condition, often are utterly unable to present their own cases.

The Reagan Administration has attempted to justify the increase in benefit terminations as an economy. This is misguided. The human cost to disabled people and their families and the financial burden imposed on state, county and city governments far outstrip any savings realized by such harsh measures. For example, loss of disability benefits often results in costly rehospitalization of serious mentally disabled people who are unable to work and who lack sufficient income to live in the community. As two staff members of the New York Psychiatric Institute recently noted in a letter published in The New York Times, "This hospitalization costs the city, the state and the Federal Government $100 to $500 a day—surely an odd way to save the approximately $15 a day that it costs to maintain a disabled person outside of a hospital with Federal disability payments."[7] Other beneficiaries end up homeless and destitute and are forced to rely on hard-pressed state and local relief programs.

The organizations listed below believe that this nation must not thus abandon its disabled citizens. We therefore urge pursuit of the following recommendations:

1. Congressional hearings, including field hearings, should be conducted as soon as possible. These hearings should address the full array of issues in the disability review process.
2. The General Accounting Office (GAO) should conduct an investigation of the Social Security Administration's practices relative to the continuing disability investigations. The study should examine the immediate and long-range impact of current SSA practices on beneficiaries and on federal, state and local governments.
3. Beneficiaries must not be terminated prior to a full and careful review of the merits of their case by appropriately qualified professionals.
4. Mentally disabled beneficiaries and those who are homebound must be provided with personal assistance (and home visits if necessary) throughout the review process.

Association for Retarded Citizens.
Epilepsy Foundation of America.
Gray Panthers, represented by the National Senior Citizens Law Center.

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[5] Supplemental security recipients, however, are entitled to receive income pending appeal. But, with some exceptions, these benefits must be repaid if the appeal is lost.

[6] SSA has told a Federal court in Kentucky that, because of the increase in workload based on the continuing disability review process, it cannot meet the 165-day (5½-month) time limit proposed by SSA in August 1980 and approved by the court. SSA is seeking a modification of that court order, freeing the agency from any specified time limit. *Blankenship* v. *Secretary, HHS*, 517 F. Supp. 77, 522 F. Supp. 618 (W.D. Ky 1981); see also Jan. 7, 1982, memorandum.

[7] Francine Cournos, M.D., and Richard Herman, "A Federal 'Shell Game' on Mental Disability," Feb. 11, 1982.

Mental Health Law Project.
National Alliance for the Mentally Ill.
National Association of Private Residential Facilities for the Mentally Retarded.
National Association of Rehabilitation Facilities.
National Easter Seal Society.
National Mental Health Association.
National Multiple Sclerosis Society.
National Society for Children and Adults with Autism.
Save Our Security Coalition.

At its February 26, meeting, the SOS coalition's exective committee passed a resolution endorsing the above recommendations in their entirety. This coalition consists of nearly 100 organizations, including the AFL-CIO, National Council of Senior Citizens, National Education Association, Paralyzed Veterans of America, United Auto Workers, National Retired Teachers Association/American Association of Retired Persons and the American Federation of State, County and Municipal Employees.

The Mental Health Law Project (MHLP) compiled the following case examples. Pseudonyms have been used to disguise individuals' identity. For additional information and for referral to advocates representing disability recipients in these and other states, telephone Jane Yohalem or Lee Carty at MHLP, (202) 467-5730, or write to MHLP, 2021 L Street N.W., Suite 800, Washington, D.C. 20036.

ARIZONA

Jim Hill is terminally ill with hystocytic lymphoma, a form of cancer. He began receiving disability benefits in 1979, after 16 years of work. His benefits were terminated in August 1981, based upon a finding that he had improved enough to work. Mr. Hill appealed and is still awaiting action on his appeal. He is suviving in the meantime on $156 per month from the state welfare department.

Roger Morris has a heart condition and is paralyzed on his right side, following a stroke. The stroke has also impaired his vision and his ability to speak. Mr. Morris' file was reviewed in October 1981. In November, the SSA declared him able to work and terminated both his benefits and his Medicare coverage. To support their two children, his wife now works seven days a week. Their telephone has been disconnected, they are behind on the rent and they have no medical insurance to pay for the care Mr. Morris desperately needs.

CALIFORNIA

Larry Wallace has both a serious mental disability and chronic back pain. He is constantly depressed and unable to concentrate, hears ringing in his ears and suffers from delusions and paranoid feelings. He spends his time at home, islolated from virtually all social contact and is unable to understand and execute even simple instructions. His doctor has concluded that Mr. Wallace poses a substantial risk of suicide. Despite this severe illness, Social Security officials have informed Mr. Wallace that he is able to return to work. He received his last disability payment in January. Since then his wife and six children have been without support.

Anne Reed had a kidney transplant several years ago and must take steriod drugs to avoid rejection of the transplanted kidney. This medication produces back and joint problems, fungus infections and frequent bladder infections. She also suffers from cataracts. The consulting physician Social Security officials sent her to see found Mrs. Reed totally disabled. Nevertheless, she received a termination notice with the "impairment not severe" box checked.

GEORGIA

Charles Farley is nearly blind (only 21 percent of normal vision) and suffers from a severe back injury. He has had five operations to treat a herniated disc and is in tremendous pain. His condition is complicated by a dependency he has developed on pain-relieving drugs. Mr. Farley has been hospitalized 24 times in the past year. The consultant physician Social Security officials sent him to see failed to evaluate either his drug problem or his pain. Based on this doctor's evaluation, he was removed from the disability rolls in October 1981. His 16-year-old daughter left school and went to work full-time to support the family, but was fired recently when her employer discovered that she was not yet 18.

William Powell, an ex-military policeman, has extensive brain damage as a result of a gunshot wound, received when he intervened while off duty to break up a fight. The wound left him partially paralyzed on his right side and affected his vision and his memory. Mr. Powell's IQ has dropped to 57—low enough to classify him as permanently disabled. He also has a problem with excessive alcohol use. Social Security officials sent Mr. Powell to a consultant for a medical examination. During the 10-minute examination, Mr. Powell was not even asked to remove his clothes, which would have revealed substantial atrophy of his muscles on his right side. His benefits were terminated, based upon the results of this examination.

INDIANA

Susan Blue suffers from severe mental illiness. She has been hospitalized more than 10 times in the last 15 years. Ms. Blue is able to live in the community with the assistance of community mental health center staff. Someone must visit her at last once each day to make sure that she remenbers to buy food. Ms. Blue has periodically tried to work but has always been fired because of her psychotic behavior on the job. Despite medical evidence that she is severely disabled, Social Security officials notified her last month that in their opinion she could return to work. She has received her last benefits check.

Samuel Rodgers has chronic schizophrenia. Without day-to-day supervision, he often forgets to eat. Despite this severe disability, Social Security officials informed him last year that, in their opinion, he was no longer disabled and could return to work Mr. Rodgers appealed this determination, but without assistance in preparing his claim, he lost his appeal last December. He is surviving with the help of a local mental health center program.

KANSAS

Daniel Cole suffers from a severe mental illness, diagnosed as paranoid schizophrenia and requiring treatment with large doses of the psychotropic drug Prolizin. Mr. Cole has been hospitalized at least six times for his illness. Before becoming disabled, he had been a truck driver. In January 1981, he tried to return to work, but his medication made him too drowsy to drive and, when he stopped taking the drug, he became disoriented and damaged one of the company's trucks. He had to stop working. The state vocational rehabilitation agency has refused to admit Mr. Cole to its program, finding him too disabled to work. However, Social Security officials terminated his eligibility in November 1981, on grounds that he had regained his ability to work the previous January, as evidenced by his brief and unsuccessful period of re-employment. No current information had been requested, nor was Mr. Cole's treating physician contacted. In February 1982, an administrative law judge found that Mr. Cole had been improperly dropped from the disability rolls.

Cynthia Johnson has severe mental disability that leaves her confused and unable to cope with stress. This, along with limited education, restricts her ability to perform even basic functions. For example, she is unable to keep track of the days of the week and confuses their order. Although the reports of her treating psychiatrist indicate she is disabled, she received a termination notice in December 1981. With the help of a legal services lawyer she is appealing the termination.

LOUISIANA

Paula Doyle has sickle cell anemia, requiring monthly blood transfusions, thrombophlebitis and ulcers. She also suffers from a back injury, the result of an automobile accident. Because of her sickle cell anemia, the surgery needed to correct some of her other medical problems cannot be performed without endangering her life. Her doctor's assessment is that she is utterly uanble to work. Nevertheless, Miss Doyle received a notice that her benefits had been terminated in September 1981. This notice of termination was her first communication from Social Security officials. She has not been asked for any information concerning her current condition and her doctor has never been contacted for an evaluation.

Bruce Brown is 11 years old. He has sickle cell anemia, complicated by an extremely serious nervous disorder. Bruce's condition makes it hard for him to take care of even his most basic physical needs. He receives monthly injections and has been placed in a special education class. Bruce's disability benefits were terminated in November 1981, without prior notice. Neither Bruce's parents nor his doctor were asked for information about his condition, nor was he sent to a consulting physician.

MASSACHUSETTS

Valery Small is a severely brain-damaged 16-year-old. Over the last few years, she learned to dress and wash herself and is in a special education class in the Boston public schools. In November 1981, Valery's family received a notice from Social Security officials stating that "based on [Valery's] work history, training and education, she is no longer disabled." With the help of a legal services attorney, Valery has appealed the termination.

Charles Lane has spent most of his life in a mental institution. Recently returned to the community, he lives in a rooming house and is able to get along only with substantial assistance. He remains hostile and has great difficulty relating to people. Moreover, Mr. Lane has never learned to read. On October 13, 1981, he received a letter from Social Security officials stating, "Because of your education, work experience and our evaluation of you, we find you ready to return to work." Mr. Lane's disability benefits were terminated on November 30, 1981. A legal services lawyer is helping Mr. Lane appeal his termination.

MINNESOTA

Hilda Christensen is mildly mentally retarded, with what is diagnosed as a "persistent paranoid personality pattern." She worked as a food handler and a home health aide, but was fired from every job. The local rehabilitation center evaluated her as not employable. Social Security officials, however, ignoring the overlay of mental illness on her mid-60s IQ, found that because she could dress herself and understand simple directions, she was not disabled. Her benefits were terminated and she is now existing on state general assistance money.

Catherine Mooney hallucinated throughout the examination by a Social Security doctor. Nevertheless, she was declared employable, even though, the report said her "difficulty with hallucinations" is not helped by medication. Her benefits were terminated and she is now in the psychiatric ward of the local hospital.

Madge Green, 51, has been hospitalized twice in the preceding year for heart problems. Her breathing was impaired and she had arthritis. On July 23, 1981, she got a notice terminating here eligibility for disability benefits. When her appeal was heard on October 22, she was so obviously disabled that the administrative law judge stopped the hearing.

MISSOURI

Joan Young has both epilepsy and a severe mental disorder. She spent her childhood in a state mental hospital and, although now living in the community, is periodically hospitalized in a regional treatment center. Ms. Young was evaluated by a consulting psychiatrist hired by the Social Security Administration, who found her unable to relate to a supervisor or to other employees and to follow instructions, and therefore unable to work. Nevertheless, Ms. Young received a termination notice in April 1981. On the day her appeal was heard, she was too disoriented to find the building where the hearing was to be held. Carrying the name of her lawyer on a slip of paper, she eventually wandered into a legal service office. Other staff located the lawyer and assisted her in getting to the hearing. The administrative law judge found her "obviously disabled."

Mary Lewis, 61, fell and badly fractured her leg. Her doctor believes that the injury will probably never heal. She is in a leg brace and is given intensive physical therapy several hours each day. The injury has made it nearly impossible for her to leave her house. When she does go out, she must be carried into and out of the house. Yet her disability benefits were terminated in October 1981.

NEW YORK

A report prepared by New York City Council President Carol Bellamy, entitled *Passing the Buck: Federal Efforts to Abandon the Mentally Disabled* (January 1982), includes the following case histories:

Alan Palmer suffers from a severe psychiatric illness. A few days after being notified by Social Security officials that his benefits were being terminated and that he was "employable," Mr. Palmer was hospitalized as delusional and a danger to others. The director of the South Beach State Psychiatric Hospital, where Mr. Palmer was hospitalized, emphasized that Mr. Palmer's hospitalization resulted from "the stress of having his livelihood cut off." In the hospital's view, Mr. Palmer cannot work.

Jane Rollen suffers from chronic schizophrenia. She has been hospitalized several times for her psychiatric condition. Until January 1981, she was homeless and slept in the streets of New York City. She now lives in a residential program. Ms. Rollen also suffers from severe back pain caused by an injury. She attributes here back pain to possession by demons. In November 1981, Social Security officials found Ms.

Rollen employable. She is appealing this determination with the help of counselors at her residential program.

OHIO

Gerard Linsey, 33, is mildly mentally retarded and brain-impaired. He also has severe psychological problems. Both Mr. Lindsey's doctors and the consultative psychologist he was sent to see by the SSA agreed that he was disabled. They concluded that he functioned well below the average and was unable to follow even simple directions. Nevertheless, Mr. Linsey received an SSA termination notice stating, "You can relate well to others and your memory is intact. Therefore you can work." The administrative law judge who reviewed Mr. Linsey's case found in the record no support whatsoever for the termination and reinstate Mr. Linsey's benefits.

William Brown has chonic pancreatis, peripheral vascular disease, liver disease, esophogeal disease, anemia, tuberculosis and chronic dementia. Yet the SSA notified him that, in the opinion of Social Security officials, he was able to go back to work as a manual laborer.

Carol Jones has a severe manic-depressive illness for which she has been hospitalized twice. Her psychiatrist's report indicates that she is isolated and withdrawn. Her illness induces anxiety so severe that her vision is blurred, she experiences frequent daily episodes of lightheadedness and she is unable to concentrate. The psychiatrist's report concludes that she cannot perform the most basic work activities—she cannot related to fellow workers, has difficulty understanding and following instructions, cannot maintain attention long enough to perform simple tasks and is unable to deal with even minimal stress. Not surprisingly, Ms. Jones failed to file an appeal within the proper time limit. Her disability benefits were terminated. Ms. Jones subsequently obtained representation by a legal services attorney and is now seeking reinstatement of benefits.

PENNSYLVANIA

Fred Rowe is a chronic schizophrenic, paranoid type. To control his illness, he takes high doses of psychotropic medication. His condition is complicated by a spastic disorder which causes him to fling his arms around and a sleep disorder which leaves him drowsy much of the time, although he sleeps 16 to 18 hours a day. Mr. Rowe's 6'5" height, aggressive appearance and flailing arms present a threatening aspect to a potential employer. However, based simply on a review of his file, Mr. Rowe's disability benefits were terminated in November 1981. He was not interviewed by a Social Security official, nor was he sent to see a consultant. As a result of his loss of disability benefits, Mr. Rowe's condition worsened and he has been hospitalized. He is pursuing an appeal.

Bernice Davis, 57, worked as a housekeeper until 1976. She has painful arthritis and a nervous disorder that manifests itself in anxiety so extreme that she lives as a recluse. Except for doctor's appointments, she rarely leaves her house. Last fall, Social Security officials found Mrs. Davis no longer disabled and ready to return to work. They made this determination without ever asking her treating physician for a report on her condition. Her benefits were terminated in November 1981. Mrs. Davis is seeking state-funded general assistance to survive while awaiting a decision on appeal.

TENNESSEE

William Thomas suffers from severe mental illness. When he received a three-page form from SSA asking for information about his illness and medical treatment, he scrawled disturbed, accusatory notes in the margins and returned the form to Social Security officials. Eight months later, Mr. Thomas received a letter notifying him that his disability benefits had been terminated because of his failure to complete the Social Security form. Further, he was told he would be required to repay benefits he had received in the eight months between the time he received the form and the date of his termination notice. Mr. Thomas is now institutionalized at Moccasin Bend State Hospital. Thanks to the help of hospital social workers, he is back on the disability rolls.

Bruce White has multiple health problems: severe back pain for a slipped disk, ulcers, kidney problems, tuberculosis, a substantial hearing loss and anxiety. Both his physician and the consultant Social Security officials sent him to see agreed that he was so severely disabled that he could not do even sedentary work. Despite the extensive medical evidence in his file documenting his disability, he was dropped from the disability rolls in July 1981. In early December an administrative law judge ordered him reinstated. Nearly three months later, Mr. White is still awaiting for his first benefits check.

TEXAS

Helen Pope is mentally retarded. She has been participating in a United Way agency's sheltered workshop program. Near the end of 1980, Miss Pope attempted to move a Goodwill Industries workshop. After a month's trial, it was clear she could not manage the job, and she was sent back to the sheltered program. In March 1981, however, she received a benefits-termination notice, giving her 10 days to appeal. She didn't understand the notice and failed to file an appeal, whereupon her SSI benefits were halted for 10 months. With the assistance of a legal services attorney, she was finally reinstated.

Sidney Bell suffers from chronic schizophrenia, which is treated with frequent injections of Prolixin, an atipsychotic medication. Mr. Bell's intelligence tests at a low level. He rarely speaks and replies to questions with one-word answers. He lives in a boarding house. A Social Security consulting psychiatrist confirmed both and diagnosis of schizophrenia and Mr. Bell's poor adaptive and functional skills, but his benefits were terminated in March 1981. Thirteen months later, he still awaits a decision on his appeal.

Chairman PICKLE. We thank you, Ms. Yohalem.

Each of you panelists are attorneys, I assume. Your general position is that we should not move up to reconsideration level, but rather keep the emphasis at the ALJ level. Is that basically correct?

Mr. GIBSON. That is very true, Your Honor, because that is the only level at the present time where we have an independent judiciary. The same people that made the previous decision, and the same people that are under all the pressures from the administration are still there taking all the pressure. We have no chance of getting a fair, impartial hearing at that level.

Chairman PICKLE. You are not making, then, a new recommendation except to keep the emphasis at the ALJ level, and in fact, just eliminate the reconsideration process entirely?

Mr. GIBSON. Yes. There is no reason at all to even have that step. There is no reason at all to have the appeals counsel, either.

Chairman PICKLE. We have a tremendous backlog at the ALJ level, and it is worsening.

Mr. GIBSON. Mr. Chairman, let me point one thing out to you. The administration says that according to the figures I got from Mr. Arner back there, they are going to have 314,000 reviews in 1982, 520,000 in 1983, and in 1984 they are going to have 832,000. If they can figure out some way to gin up enough ALJ's to handle that, then they can certainly give us a fair program with enough administrative staff at the ALJ level to have staff hearings and hold them properly.

By eliminating the recon level, and if they want to eliminate the attorney fee branch and eliminate the appeals branch, streamline this thing down, they could put the resources into the effective positions, a good initial determination, a good law judge, and we are not really sure whether the Federal court or the special court is the way to go, but whatever it is, have a three-step program.

I know of no place in the world where they have seven appeal steps, and remands, and reconsiderations, and it is just a hodgepodge when you try to deal with it. The Federal court sends it back to the appeals counsel. The appeals counsel sends it back to the judge. The judge recommends another decision. He sends it back to the appeals counsel. They either accept it, reject it, send it back to the Federal court. The time just shipping involved would probably pay half our salaries in this program. It needs to be streamlined. It needs to have three distinct steps which are all effective, and cut out all of the rigamarole in between.

You did mention one thing about, I think you said, about the two out of the last six requirement for insured status. There were some comments made about, oh, you only have to work another 10 months or 11 months and you are reinstated. That is the kind of Mickey Mouse we don't need in the program. If a guy comes in to me and I look at him, right now he has to work one out of the last six. Now you are saying, OK, he has to work two out of the last six. If he hasn't worked two out of the last six, you say, go out, pick up cans, go to the park, and swap. At end of the year on your tax return file that you had $1,200 self-employment insurance. Get four more quarters, and then we will go in and see about——

Chairman PICKLE. Is that what you recommend as an attorney? Is that the practice you follow?

Mr. GIBSON. That is the kind of thing that comes out.

Chairman PICKLE. Is that what you inform your client to do?

Mr. GIBSON. No, Your Honor, that is not what I inform them to do, but that is the kind of thing that can develop out of this type of program, where all you are looking for is some kind of an artificial coverage, without regard to whether the person has or——

Chairman PICKLE. Do you say we shouldn't have a recency test now?

Mr. GIBSON. We have a perfectly good one now. I don't see any reason to make a change just because somebody only has—what was it?

Chairman PICKLE. Six out of 13.

Mr. GIBSON. Six out of 13. We will say, we won't do that. Let's do something else. Let's give them two out of the last six. If that is the only reason, let's not have it. Let's not make fixes which we do not need.

Chairman PICKLE. I asked my State agency people if we should have uniform POM's both at the State agency and reconsideration and with the ALJ's. I met with 200 representatives of my State agency recently. I asked for a vote on it. I think the vote was about 190 in favor of doing that. Now you testify that we ought not to apply it. It ought not to be held applicable. Let the ALJ have freedom of interpretation entirely.

Mr. GIBSON. Strictly with the law, the regulation, the court decision. If you want to have a vote, I can get you 200 attorneys and they will all vote no on having a POM's.

Chairman PICKLE. I think I know what the attorneys' positions would be in most of these procedures, but aside from what claimants would be pushing for, we are trying to find a better procedure to speed up the consideration. We are not going to cut out the remand section. We are not trying to add to this procedure at all. We are trying to put more emphasis at an earlier level in the hopes that that might establish more record earlier on before it gets to the ALJ. It will give them more in-depth consideration. I don't know whether it is the right procedure or not. I think it would speed it up. At least it would make reconsideration meaningful.

I appreciate your recommendation. We are glad to have it, and we will be receiving testimony, and we will keep our record open for a while for all organizations to submit their statements.

Mr. ROUSSELOT. Thank you, Your Honor. [General laughter.]

We call him Chairman.

Ms. Shor, I notice at the conclusion of your testimony you ask that we keep the record open past March 31. Why do we need to do that?

Ms. SHOR. Mr. Rousselot, the reason for my request is that as the chairman indicated, many provisions of this bill were introduced in the disability amendments of 1981 and are not new. The one that is new, and the one that I think deserves some serious consideration, is the question of closing the record of reconsideration.

Mr. ROUSSELOT. What made you think we were not giving it serious consideration today?

Ms. SHOR. We are just interested in another 2 weeks to notify other organizations and people who may be interested in expressing their views on whether this is a good idea.

Mr. ROUSSELOT. Can they not submit their ideas to us before the 31st? These ideas which you suggest they might submit are not brand new. They have been thinking about them certainly. We had a bill last year. Now we have another bill.

Ms. SHOR. Correct, but my understanding is, this particular provision was not included in the bill last year, and for most of us this press release of approximately 10 days ago was the first notice that this change in the disability function was on the table.

Mr. ROUSSELOT. There are problems in this program which we need to address now. We cannot wait forever. How much longer do you think we should delay?

Ms. SHOR. If asked for a figure, I think probably 1 month would be sufficient. My concern is that this provision is going to increase the delay, and is going to increase cost without increasing the adequacy of decisions.

Mr. ROUSSELOT. Well, you stated that in your testimony.

Ms. SHOR. Yes, sir.

Mr. ROUSSELOT. Why would you think we would consider what you said?

Ms. SHOR. I hope you will consider what I said.

Mr. ROUSSELOT. Why do we need more people to tell us that?

Ms. SHOR. I think you will find that this particular provision is based on some misconceptions of why the record is the way it is at reconsideration and perhaps the kind of examples that will be furnished to you, I think, will enable the subcommittee to examine carefully the underpinnings of why reconsideration——

Mr. ROUSSELOT. Well, why cannot others that you feel must tell us about that do it before March 31?

Ms. SHOR. We will certainly make every effort to see that they do.

Mr. ROUSSELOT. Thank you for your testimony. It was certainly well thought out.

Mr. Gibson, I am fascinated by your representation of the social security applicants which you describe briefly in your paper here. Are you for or against H.R. 5700?

Mr. GIBSON. There are many portions of the bill that we don't have a position on. As far as keeping it, if you just pass it or fail it, I would say turn it down.

Mr. ROUSSELOT. Turn it down?

Mr. GIBSON. If you are talking about its entirety.

Mr. ROUSSELOT. In other words, as it stands now, you do not favor H.R. 5700?

Mr. GIBSON. No, primarily for the emphasis on the POM's portion and emphasis on the closing the record at recon.

Mr. ROUSSELOT. So there is enough in the bill that you feel is not helpful for us to vote against it?

Mr. GIBSON. Yes.

Mr. ROUSSELOT. We can't vote "maybe" when we report out a bill. We have to be specific. And I can see many of your complaints about the bill, but you didn't say you are for or against it, which the other two stated. They named specific changes where they tried to state where they favored portions of the bill.

Now, I am terribly intrigued with your comment that the committee should get input from the grassroots. One of the ways you suggested we do that is to come to Phoenix. Are there other places we can go to get input from the grassroots, and why aren't we getting grassroots today?

Mr. GIBSON. Well, one of the things is the expense involved. I personally flew here at my own expense.

Mr. ROUSSELOT. We appreciate that. The Federal Government appreciates that.

Mr. GIBSON. I represent also 15 other attorneys that would like to put in their own views.

Mr. ROUSSELOT. But you took a poll among them and represent their views.

Mr. GIBSON. Yes. We will be submitting additional comments, because we assigned different portions of the bill for people to write on, but due to the time limit, I didn't have time to get the comments from them.

Mr. ROUSSELOT. I am also intrigued that you feel we need to eliminate so much of the bureaucracy. Is that what you stated, at the different levels? I think you talked about three levels that are important enough to retain.

Mr. GIBSON. Yes.

Mr. ROUSSELOT. You see a clean-cut three-level system. Can you think of a way to put that in a legislative package?

Mr. GIBSON. I obviously have not drafted a bill for anybody. I don't think it would be that difficult to say that you would have——

Mr. ROUSSELOT. I would be intrigued to see what you think would be a clean-cut three-level system in law.

Mr. GIBSON. I can see no reason for having reconsideration levels, whatever legislation you draft. Presently, we have a bill that authorizes an initial determination. That should be a good initial determination. Some effort should be put in there to make it proper at that point.

Mr. Rousselot. How do you suggest we do that?

Mr. Gibson. The system you have at the present time——

Mr. Rousselot. Has problems.

Mr. Gibson. I am not so sure that the initial—the initial determination level, the biggest problem is that they use internal directives rather than looking at whether or not the person who is disabled is able to perform substantial gainful activity. That is set forth clearly in the law, the regulations, and the court cases. But on top of that is superimposed all of the POM's and the internal policy and all of those things, because you have a large number of bad decisions coming out there.

Mr. Rousselot. How would you amend current law to change that?

Mr. Gibson. I don't think it is possible, particularly to change that, unless you put in the law that the local level will follow the law and regulations and case law and will not add to it.

Mr. Rousselot. Case law and important decisions?

Mr. Gibson. Yes.

Mr. Rousselot. Then the cases will be based on those criteria. Then after that you go to a judge, and he has an opportunity to see the person and take the subjective elements into consideration—the person's credibility, the person's appearance—things that judges have to take into consideration at the time they decide the case. If we don't like the decision we get there, then go to a Federal court, or the judicial courts which you are talking about establishing. It would cut a lot of the bureaucracy out. It would cut a lot of the delays out.

Many of us are interested in eliminating unnecessary bureaucracy. We need suggestions for specific amendments to accomplish that. Are you willing to do that?

Mr. Gibson. I would be willing to work with anybody.

Mr. Rousselot. You are a lawyer.

Mr. Gibson. Yes.

Mr. Rousselot. I am sure you could help us.

Mr. Gibson. I would be very happy to try to work with you.

Mr. Rousselot. Terrific.

Mrs. Yohalem, I was impressed by your thoughtful testimony. In the Mental Health Law Project, do you represent both mentally retarded and mentally disabled?

Ms. Yohalem. That is right, mentally retarded and mentally ill, both.

Mr. Rousselot. My understanding is that presently there are 629,000 in the mental illness category and 329,000 in the mental retardation program in this law. How many of those would you say are adversely affected by some of the problems you highlight?

Ms. Yohalem. I don't have specific figures.

Mr. Rousselot. Roughly.

Ms. Yohalem. If the reviews are going to extend to all people, eventually they will all at some level be affected if proper law and regulations are not applied when their cases are reviewed. A portion of the mentally retarded at this point probably fall in the permanently disabled category and are not being reviewed, but we are seeing a surprising number of mentally retarded people as well as mentally ill people calling us, or their representatives calling us, about terminations.

Mr. ROUSSELOT. When you say representatives, do you mean their attorney representatives, as opposed to Members of Congress?

Ms. YOHALEM. Yes; either lawyers or treatment professionals who are involved in helping someone fill out the forms.

Mr. ROUSSELOT. If you had to guess, who would you say are the people who are adversely affected in these two categories presently?

Ms. YOHALEM. The numbers you are asking?

Mr. ROUSSELOT. Percentage.

Ms. YOHALEM. Percentage. I do not know. I have been trying to get figures, identifying mentally ill and mentally retarded separately, from the Social Security Administration, and they at this point claim that they don't have those compiled. So it has been very difficult to estimate accurately.

Mr. ROUSSELOT. Maybe you can go back and try to help. I ask that question because your statement is very well thought out, and you have taken a lot of time to indicate to us areas in this bill that you think will present a problem for these two categories. I just think it would be helpful to us to know what percentage of these groups are really going to face this.

Ms. YOHALEM. I think the percentage in the area of mental illness is extremely high. What the case examples are showing is the only people who are mentally ill who are not being carefully reviewed and subjected to terminations based on employability criteria are those who are so disabled—one State agency described the people who were being left on the rolls as people so ill they were being tied up in a straitjacket. They were so disabled that it was quite obvious that they were physically incapacitated as well as mentally incapacitated.

The cases we are seeing in the mental illness area cut across people who are chronic schizophrenics. They are not just people suffering from neurosis. Many of them are people who have been repeatedly hospitalized, or who have spent a good portion of their lives in a psychiatric institution, and are now out in the community, but living in halfway houses or group homes with substantial support from treatment professionals and others daily.

Let me give you an example of the people who are being dropped from the rolls. A psychologist at a community mental health center described several clients where community health center staff visit the person daily to make sure that they buy food and they in fact eat, and yet that person received notice that his benefits have been terminated.

Mr. ROUSSELOT. Thank you, Your Honor.

Mr. GIBSON. May I just make one more comment?

Chairman PICKLE. Yes, Mr. Gibson.

Mr. GIBSON. When you are talking about grassroots, to give you an example of talking about the things we might be able to tell you about, you are all familiar with the SSI windfall program where it kind of amazed me as an attorney for years, for approximately 7 or 8 years we paid a person general assistance all the time he was in litigation, after we got a favorable decision for him, they went back and paid him for SSI for the same *period. Then they paid him or* DIB for the same period. So he drew a general assistance check.

That always seemed to me coupling up a lot of benefits which the Government really shouldn't have had to pay for.

Mr. ROUSSELOT. You have tried to help correct that?

Mr. GIBSON. That is the kind of thing—at the present time, when a person is found to be in a windfall category, the way they handle it, instead, they first determine he is disabled. They second go in and have a redetermination proceeding to determine what his earnings are. Then they pay him the SSI. Then they pay him the monthly DIB check. After they pay him the monthly DIB check, they go back in and say, OK, let's find out how much we overpaid him on the SSI. Then they subtract whatever payment from the DIB plus the fact that he has probably gotten 1 or 2 months of dual payments from both SSI and DIB.

Why don't they work to make some simple procedure where the initial thing to do is find out, is his DIB payment going to be over $284 a month. If it is over $284 he gets no SSI check. Then you can skip all that other termination work and trying to collect overpayments.

Those things seem simple enough to me. I don't know if anybody has really thought about trying to do it that way, but it is the kind of thing, you know, like we could suggest to you. That is the kind of thing that I think you all ought to look at to cut out these overpayments of people getting more money than they should get.

Mr. ROUSSELOT. Thank you.

Chairman PICKLE. I thank the panelists for your testimony and your suggestions. If you have other comments you wish to submit to us in the immediate days ahead, we would be glad to receive them.

Mr. ROUSSELOT. Mrs. Shor has other people who she thinks can submit comments quickly, hopefully.

Chairman PICKLE. Fine. If time will permit it——

Mr. ROUSSELOT. Well, she would submit——

Chairman PICKLE. The testimony will be submitted; yes.

[The following was subsequently received:]

CAPRA & BECKETT,
ATTORNEYS AT LAW,
Phoenix, Ariz., March 25, 1982.

MR. JOHN J. SALMON,
Committee Ways and Means,
Washington, D.C.

DEAR MR. SALMON: I am writing on behalf of People United for Self Help, Inc., an advocacy group composed of disabled persons, social service professionals, and attorneys. Specifically, I am addressing Section 13(a) of H.R. 5700 pertaining to attorneys' fees in Social Security cases.

As we understand section 13(a), the Secretary could not spend money on the process of approving fee petitions so presumably no such process would occur. Further, the provision would eliminate the current certification for payment of past due benefits directly to the attorney. We believe these provisions fly in the face of long standing legislative policy, history and law in assuring that Social Security claimants are adequately represented but not excessively charged for that representation.

In 1965, Public Law 89-97 added 42 U.S.C.(b) providing that whenever a federal court rendered a judgment favorable to a claimant who was represented by an attorney, the court could determine a reasonable fee for such representation, not in excess of 25 percent of the past due benefits to which the claimant is entitled. The amendment also provided for the Secretary to pay the court awarded fee directly to the *attorney from the claimant's* past due benefits. The amendment provided that any attorney who charged more than a court award was guilty of a misdemeanor and subject to a fine of not more than $500.00, or imprisonment of not more than one year, or both. The rationale for this amendment is found in Senate Report No. 404, p. 2062, 1965 U.S. Code and Cong. and Adm. News:

"It has come to the attention of the committee that attorneys have upon occasion charged what appear to be inordinately large fees for representing claimants in Federal district court actions arising under the social security program. Usually, these large fees result from a contingent-fee arrangement under which the attorney is entitled to a percentage (frequently one-third to one-half) of the accrued benefits. Since litigation necessarily involves a considerable lapse of time, in many cases large amounts of accrued benefits, and consequently large legal fees, are payable if the claimant wins his case.

"The committee bill would provide that whenever a court renders a judgment favorable to a claimant, it would have express authority to allow as part of its judgment a reasonable fee, not in excess of 25 percent of accrued benefits, for services rendered in connection with the claim; no other fee would be payable . . . In order to assure the payment of the fee allowed by the court, the Secretary would be permitted to certify the amount of the fee to the attorney out of the amount of the accrued benefits."

Consistent with this rationale, Public Law 90-248 was enacted in 1968 providing for a similar fee approval process with respect to claims before the Administration. We believe this rationale is valid and that the process is working. That such a process is a governmental function is not at all unusual when dealing with claimants/clients who are in relatively vulnerable positions. Fee approvals with fee guidelines are common elements of workmen compensation cases and of probate cases dealing with incapacitated or deceased persons. Eliminating the certification of payment can only result in claimants finding fewer attorneys who will handle their cases and those attorneys requiring stiff if not prohibitive retainers (to be placed in trust accounts of course until fee approval is obtained).

If deregulation for deregulation's sake wins out, then the only realistic way to assure the availability of representation is to adopt a "personal injury" type system. Either Social Security could simply pay an attorney 25 percent of the past due benefits in all cases or the Administration could send the past due benefits check to the attorney who could disburse the check to his client after disbursing the agreed upon fee to himself.

We appreciate the opportunity to review and express our views on this issue.

Sincerely,

ROBERT BECKETT.

Chairman PICKLE. Thank you very much.

Now we have a panel represented by Mr. George Watters and Mr. John Harris. This is the last panel for the day. Will Mr. Watters and Mr. Harris take a place at the witness table?

[Pause.]

Chairman PICKLE. Now, Mr. Watters, or Mr. Harris, or jointly, had asked that this testimony be recorded by film, and I presume by sound. If he wishes to have portions of it, that will be agreeable to the committee. We have checked the committee previously.

I must stress to you that you have lengthy statements, and the hour is getting late. I would prefer to go ahead and to make the best of our time. It is now a quarter to 1. Is that agreeable to you?

Mr. WATTERS. Yes, Mr. Chairman.

Chairman PICKLE. If you could summarize, we would appreciate it. If you want more time, we will come back this afternoon, or keep you over until tomorrow, but I would like to proceed with the testimony if that is agreeable.

Who wishes to speak first? Mr. Watters?

Mr. WATTERS. Fine, Mr. Chairman.

Chairman PICKLE. Mr. Watters is the vice president, product design and development, and he represents the Ability Information Systems. We are pleased to have your testimony.

STATEMENT OF GEORGE M. WATTERS, VICE PRESIDENT, PRODUCT DESIGN AND DEVELOPMENT, ABILITY INFORMATION SYSTEMS

Mr. WATTERS. Thank you very much.

Ability Information Systems is a private for-profit corporation that was designed under the basic concept that ability of disabled people was a viable, profitmaking aspect of our society.

The proposal that I would like to make here today is based upon discussion that I have had for the last several years with various people of the Social Security Subcommittees, the Senate Finance Committee, the staffs of the Ways and Means Committee, the disability examiners, administrative law judges, vocational experts, Congressmen outside of the disability-related areas, administrative input, national organizations of the social security claimants' representatives, the disabled people themselves, and the rehabilitation professionals. It is a synthesis that took 3 years of investigation and work in this area.

In the midst of attempting to tighten and standardize consideration of medical factors, let us not forget the core definition of "disability"; that is, the inability to engage in substantial gainful work activity by reason of those physical or mental disabilities.

In our view, high technology data management offers a key ingredient for a practical solution to disability adjudication. Through the appropriate use of high technology, we believe pertinent facts can be organized for clear understanding. Once that is established, we will be able to return to this critical area the best element of the system: human interaction and judgment.

By allowing the computer to accomplish the herculean task of correlating into relevant data the disability examiner and administrative law judge will be able to exercise their judgment on the basis of independent perspectives but common standards.

While we realize that the Social Security Administration is currently grappling with an immense data processing crisis, in our judgment this is more the result of a vast effort at centralized standardization than trying to accomplish precise personal computing. In the field of disability systems, high technology data management holds great promise not only to solve human problems, but also to make possible the new kinds of political coalition building we need in order to solve the problems of the day.

We believe those who are profoundly committed to Government's role as a shepherd of human services will identify in high technology data management the tool required to enhance the sensitivity to the individual needs in a complex society. At the same time, those with the greatest insights into our current economic exigencies and all the ramifications should find this approach to data management the most reliable means to stretch scarce resources to the utmost.

In this context we would like to introduce to you the approach of Ability Information Systems. This approach confirms the intent and spirit of social security disability legislation and regulations by providing a technology which performs tasks otherwise impossible to perform.

We believe it is time to challenge the myth that computers depersonalize our lives. Technology can be used in an appropriate way to restore individual dignity and the integrity of a system which has broken under the weight of super human being needs.

The Ability Information System is based on the same microcomputer technology that is already available through use in homes and which proliferates in the form of computer games throughout our Nation's shopping centers and pizza parlors. Obviously people who use microcomputers are not required to be data processing experts.

The Ability Information System computers are operated by a simple keyboard similar to that found on a typewriter, which an adjudicator can learn to use effectively with 2 days' training. In addition, our computers tutor the adjudicator at each step of the process by explaining through directions on the screen how to perform each task. It is also possible to backtrack through the system so that adjudicators and claimants and the computer truly interact.

Let us take a hypothetical case of a disabled applicant with prior work experience as both a telephone repairman and a carpenter. The adjudicator for such an applicant first enters the title "carpenter and telephone repairman" into the computer. On its screen the computer displays a complete description and profile for each job. These can be examined at length.

When the adjudicator directs it to do so, the computer summarizes or correlates the skills, experiences, and aptitudes applicable to both jobs into a single overall assessment. Any number of jobs can be thus summarized.

In the next step, the adjudicator prepares a profile for the systems review which outlines the abilities and disabilities of the client and tells the computer what type of physical or mental disability to consider. Let us say that our hypothetical worker is now restricted to performing only light tasks as defined in the regulations and by the Department of Labor.

This is an extremely simple example, and is actually 1 variable of 122 variables that are considered by this particular system. Worker trade characteristics are standardized in accordance with Federal regulations in this system. The computer makes the presentation of several hypotheticals possible. The computer then searches through the 12,099 dictionary of occupational titles and job code classifications and finds those which require similar skills for telephone repair and carpentry, and are also designated as requiring reduced physical demands at the light level.

Here the value of the data processing system is dramatically demonstrated. The computer, in less than 5 minutes, searches and finds 22,041 relevant job codes for our hypothetical worker; it rejects 2,037 codes; and selects 204 which meet the profile of that particular individual.

The computer not only locates relevant codes, it correlates them with logic formats required by Federal regulations. For example, it takes the age and applies a special procedure for people who are age 55 and restricted to sedentary work, or who are age 60 and are restricted to light work per the regulations.

Our hypothetical worker now has a list displayed on the screen of 204 job codes which utilize prior work experience and reflect current skills. The system contains a further refinement with important applications to the adjudication of disability claims by tapping into the regional job information regularly updated for accuracy by use of county business patterns and structures and such things.

The computer next correlates the selected job skills with those jobs which are likely to actually exist within the applicant's region of residence. Again, this task is performed in minutes, and yet covers a much wider range of information than an adjudicator could consider during a manual examination.

This answers the question posed in the regulations as to whether or not jobs exist in significant numbers in the national economy as reflected in the area of a person's residence, or several other areas accompanying it.

The previous summary presents a simplified version of a hypothetical case. As an adjudicator familiarizes himself with the system, more sophisticated uses become available. The system contains the capability to be guided by specific Code of Federal Regulations provisions for age, education, and work experience. The system can be adapted for use by attorneys, law judges, examiners, counselors, administrators, and can even be made accessible to the disabled people themselves.

Interestingly, roughly two-thirds of the people who apply for social security disability benefits are turned down on the first try. How many of those people would not apply if they had adequate information regarding how their particular ability profile matched with the world of work around them?

The potential of the system ultimately makes the slogan, "disabled does not mean unable," a reality because a constructive direction for rehabilitation has been clarified as a byproduct of the adjudicator process.

In conclusion, the system provides a legally defensible and humane evaluation of an applicant's ability to perform work, and thereby reduced costly appeals through the adjudication process. If for example the computer finds no job codes applicable to an individual within the region of residence or other pertinent regions in the country, that person can be quickly and defensibly certified as disabled.

On the other hand, adjudicators now have a tool for logically and legally denying an appropriate claim to the basis of the law with a statement of inability to engage in substantial gainful work. An important psychological factor has been entered into the entire disability adjudication rehabilitation system. Instead of focusing on disability, individuals are gently directed in a positive manner to focus on abilities.

The system makes possible for the first time in the history of the social security disability program the correlating of complex tasks and information necessitated by our concern for individual assistance to the disabled. This injects a high level of objectivity and a common standard. The rapidity and sophisticated technology of the system is astounding but not of paramount significance.

The capacity to use advanced technology is not enough. Its use must be tempered by human concerns and interaction. We believe that we can make a difference in the lives of millions of our citizens by restoring their ability to contribute to their own and society's welfare.

We suggest that this hypothesis now be tested in a pilot program in a specific area of the country. Specifics regarding program office personnel and equipment needs are available on request from Ability Information System. I would just like to make one additional comment.

That is, that if an amount of money equal to one-fifth of this month's 2 percent data processing overpayments were set aside to thoroughly study this issue of the appropriate use of personal computing, we could look at this and figure out some solutions in this area.

[The prepared statement follows:]

STATEMENT OF ABILITY INFORMATION SYSTEMS

DISABILITY ADJUDICATION

The problem

The problem of adjudicating Social Security disability benefits today can be easily summarized: current administrative practices within the system resulting from the lack of appropriate data management technology make it humanly impossible to reconcile the lofty and practical intent of the law with the infinite combination of facts which should affect its application. The result is a stunning waste of national resources at a time in our history when we can least afford it, plus compounded human suffering that is most unpleasant to contemplate.

The spirit of the law dealing with disability benefits, and the letter of the regulations which guide it, dictate that benefits will be provided those citizens whose disabilities prevent them from earning their own income (20 C.F.R. 404.1571). That's the lofty part of the law. The practical side is that physical or mental limitations are not meant to be "occupations in themselves" if they do not actually prevent a person from earning a living. Both elements of the law are rooted in important American values: compassion and self-sufficiency, two indications of our country's dedication to human dignity. Here, then, is a law and an intended practice of government every American citizen can be proud of.

On the surface it might seem that nothing could be easier than honoring the clear goals of disability law. However, those who have worked within disability-related systems for a long time know what a challenging, frustrating and occasionally heart-breaking job it can be.

Specifics

When a worker lost part of his vocational capability in the days of coopers and cartwrights, an understanding of how his remaining skills fit in elsewhere in the basic economy was relatively straightforward. Today, our high-technology, highly specialized, service-oriented, interconnected economy represents a matrix of employment components that stretches from coast to coast and encompasses variables ranging from training, experience and education to personality traits, areas of interest and God-given aptitudes. More than ever before, "disabled" Americans should be able to free themselves from that crippling label by transferring their human talents (which are badly needed) to different but appropriate sectors of the marketplace. If this is done, individuals will preserve for themselves the dignity of self-supporting work and our whole society will continue to benefit from their productive contributions. Unfortunately, this transfer of talent is not taking place on anywhere near an adequate scale.

Because the profusion of disability-related information, which is a byproduct of our complex economy, is now being handled using manual, clerical and administrative methods—that is, methods more in keeping with the age of coopers and cartwrights—huge volumes of facts are being neglected. These facts deal with the modern realities of what really constitutes worker disability, the way in which transferable residual skills can be applied in today's multifaceted economy and how rehabilitation can be made most effective both in the personal and social context.

Human lives and national resources hang in the balance when this information is administered. But, because the information is so extensive, true evaluation of it can now only be approximated through the use of what we call "rational shortcuts." A look at random cases shows an overwhelming incidence of error resulting from these rational shortcuts. At the present time, the only way the system has to compensate for this error is to add to the bureaucracy. The more complex the bureaucracy becomes, the more inconsistent it gets.

As an illustration of this, consider that at the present time 63 percent of all applications for benefits are denied during the initial review by state agencies acting in accordance with the criteria of the Office of Disability Policy. Of the cases later appealed, 84 percent are again denied at the reconsideration level. In the end, 61 percent of the denials taken before administrative law judges are reversed. These reversals of previous denials are based on supposedly compatible criteria. Therefore, clients of the system who are ultimately judged to be deserving have suffered unnecessarily, and administrative and clerical costs associated with the original denials are wasted.

As a specific example of the kind of built-in bureaucratic contradictions which create reversed judgments, I would like to cite a statement made to me by Rhoda M. Greenberg, director of the Office of Disability Programs, in a letter dated May 4, 1981. "[In adjudicating disability] the regulations presume a method which can cut across the various subgroups." Ms. Greenberg's interpretation of the regulations means that the "subgroups" or other types of available work a person might be able to take up are to be considered in deciding whether to award benefits. I can only conclude Ms. Greenberg's view represents wishful thinking because of the ponderous data included within the subgroups. The "Guide To Effective Vocational Expert Testimony For Use By Vocational Experts" (who testify before administrative law judges) gives instructions precisely contrary to Ms. Greenberg's. Under Section C, "Transferability of Skills," it states: "Thus, after identifying the work-group of the claimant's prior occupation, the VE (Vocational Expert) can then ascertain which occupations in the same work-group, if any, are compatible with the hypothesized medical restrictions and further, involve use of same or similar tools and machines, raw materials, products, processes or services as the prior occupation." In other words, as directed in the regulations, Ms. Greenberg recommends that her arm of the bureaucracy include all subgroups—an impossible task without technology. Contradicting that, administrative law judges suggest that their arm should limit itself to work groups, thus making use of rational shortcuts indefensible by the regulations. Little wonder the incidence of reversal is so high.

Contradictions like this point to the maddening subtleties of our current bureaucratic tangle, at the heart of which is this fact: severe, medically diagnosable impairment is not necessarily disability. Disability is defined by an interaction of variables, of which impairment is only one. The other variables consist of a host of vocational factors. The standard for adjudicating disability, then, must be the interaction of these variables. While it is imperative that examiners and administrative law judges bring their own special perspectives to adjudication (for the sake of checks and balances), it is equally vital that their perspectives focus on a common standard of factual integration. A common standard is now missing because (1) manual correlation of all the facts is impossible, and (2) disability examiners and administrative law judges often look at different sets of facts, a de facto use of separate standards.

Consider a lecturer who loses the use of his vocal cords. Using medical factors alone, he might be ruled completely disabled. If vocational factors were integrated, however, he might be provided interim disability assistance while receiving rehabilitation that could launch him on a career as an author of books. More to the point, he might also discover a dozen other options for his future if all his skills, knowledge, aptitudes, etc. are honestly taken into consideration. No sound conclusion about his future vocational ability can be drawn without correlating all these factors.

Only by providing for the concrete, methodical handling of all pertinent facts can we hope to gain control of a confused and often capricious bureaucracy which now wastes resources and does not fulfill our hopes for providing human services.

Solution

In our view, high-technology data management offers a key ingredient for the only practical solution to disability adjudication. Through the appropriate use of high-technology, we believe pertinent facts can be organized for clear understanding. Once that is accomplished, we will be able to return to this critical area the best element of the system—human interaction and judgment. By allowing the computer to accomplish the Herculean task of correlating the relevant data, the disability examiner and administrative law judge will be able to exercise their judgment on the basis of independent perspectives but common standards.

While we realize that the Social Security Administration is currently grappling with an immense data processing crisis, in our judgment this is more the result of a vast effort at centralized standardization than trying to accomplish precise personal computing.

In the field of disability systems, high-technology data management holds great promise not only to solve human problems but also to make possible the new kind of political coalition-building we need in order to solve the problems of the day. We believe those who are profoundly committed to government's role as a shepherd of human services will identify in high-technology data management the tool required to enhance sensitivity to individual needs in a complex society. At the same time, those with the greatest insights into our current economic exigencies and all their ramifications should find in this approach to data management the most reliable means to stretch scarce resources to the utmost.

In this context we would like to introduce to you the approach of Ability Information Systems.

The AIS approach

The AIS approach confirms the intent and spirit of Social Security disability legislation and regulations by providing a technology which performs tasks otherwise impossible to perform. At AIS we believe it is time to challenge the myth that computers depersonalize our lives. Technology can be used in an appropriate way to restore individual dignity and the integrity of a system which has broken under the weight of superhuman research needs.

The AIS System is based on the same micro-computer technology that is already available for use in homes and which proliferates, in the form of computer games, throughout our nation's shopping centers and pizza parlors. Obviously, people who use micro-computers are not required to be data processing experts. AIS computers are operated by a simple keyboard, similar to that found on a typewriter, which an adjudicator can learn to use effectively with two days' training. In addition, our computers "tutor" the adjudicator at each step of the process by explaining, through directions on the screen, how to perform each task. It is also possible to backtrack through the system so that adjudicator, claimant and computer truly interact.

Let us take the hypothetical case of a disabled applicant with prior work experience as both a telephone repairman and carpenter. The adjudicator for such an applicant first enters the titles "carpenter" and "telephone repairman" into the computer. On its screen, the computer displays a complete description and profile for each job. These can be examined at length; there are no time limits built into the system.

When the adjudicator directs it to do so, the computer summarizes, or correlates, the skills, experiences and aptitudes applicable to both jobs into a single overall assessment. Any number of job titles can be summarized.

In the next step, the adjudicator prepares a profile for the system's review and tells the computer what type of physical or mantal disability to consider. Let us say that our hypothetical worker is now restricted to performing only "light" tasks. (This is an extremely simple example, with only one variable; up to 122 variables can be entered into a worker's profile. Worker trait characteristics are standardized in accordance with federal regulations.) The computer makes the presentation of several hypothetical cases possible.

The computer then searches through the 12,099 DOT job code classifications and finds those which require similar skills to telephone repair and carpentry, and are also designated as requiring reduced physical demands at the "light" level. Here the value of a data processing system is dramatically demonstrated. The computer, in less than five minutes, searches and finds 2241 relevant job codes for our hypothetical worker. It rejects 2037 codes and selects 204. This is what we mean by a "physical and logical" search. The computer not only locates relevant codes, it correlates them with logic formats required by federal regulations. Our hypothetical worker now has a list displayed on the screen of 204 job codes which utilize prior work experience and reflect current skills. Remember that this task, if performed manually, might require months or years of tedious research on the part of the adjudicator.

However, the AIS System contains a further refinement with important applications to the adjudication of disability claims. By tapping into regional job information (regularly updated for accuracy), the computer next correlates the selected job codes with those jobs which are likely to exist within the applicant's region of residence. Again, this task is performed in minutes and yet covers a much wider range of information than an adjudicator could consider during a manual examination. This answers the question posed in the regulations as to whether or not jobs exist in significant number in the national economy as reflected in the area of a person's residence or several other areas of the country.

Incidentally, since the AIS System effectively frees counselors to do what they do best—counsel—it enhances the one-to-one relationship which supports and encourages disabled workers. Using other AIS components, job codes can be reviewed with the applicant. During the review the counselor provides expertise in such areas as community educational resources, rehabilitation courses, job placement possibilities and personal needs. The counselor can realistically determine the applicability of job codes to individuals. Our system also prints from the display screen so applicants can later review selected codes at home. AIS helps the counselors to suggest a reasonable job search strategy for the applicant.

This summary presents a simplified version of a hypothetical case. As adjudicators familiarize themselves with the system, more sophisticated uses become available. AIS contains the capability to be guided by specific provisions for age, education and work experience in the Code of Regulations.

The AIS System can be adapted for use by attorneys, law judges, examiners, counselors, and administrators, even disabled people themselves. The potential of the system ultimately makes the slogan "Disabled Does Not Mean Unable" a reality because a constructive direction toward rehabilitation has been clarified.

In conclusion:

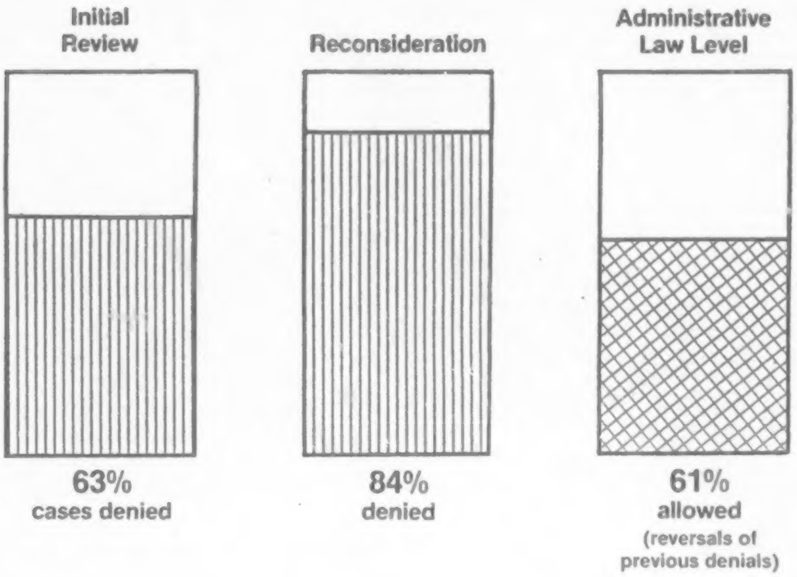
(1) The AIS System provides a legally defensible and humane evaluation of an applicant's ability to perform work and thereby reduces costly appeals through the adjudication process. If, for example, the computer finds no job codes applicable to an individual within the region of residence, that person can be quickly and defensibly certified as disabled. Benefit payments begin immediately, eliminating the financial crises which truly disabled individuals have often endured in the past. On the other hand, adjudicators now have a tool for logically and legally denying inappropriate claims, thus reducing payments which actually demean the system and the individuals involved in such practices.

(2) An important psychological factor has been entered into the entire disability/adjudication/rehabilitation system. Instead of focusing on disabilities, individuals are gently directed, in a positive manner, to focus on abilities.

(3) The AIS System makes possible, for the first time in the history of the Social Security disability program, the correlating of complex tasks and information, necessitated by our concern for individual assistance to the disabled. This injects a high level of objectivity and a common standard. The rapidity and sophisticated technology of the system is astounding, but not of paramount significance. The capacity to use advanced technology is not enough; its use must be tempered by human concerns and interaction. AIS believes that we can now make a difference in the lives of millions of our citizens by restoring their ability to contribute to their own and society's welfare.

AIS suggests that this hypothesis now be tested in a pilot program in a specific area of the country. Specifics regarding program office, personnel and equipment needs are available on request from Ability Information Systems.

Administrative Review Reversal Rate In the Disability Adjudication Process*

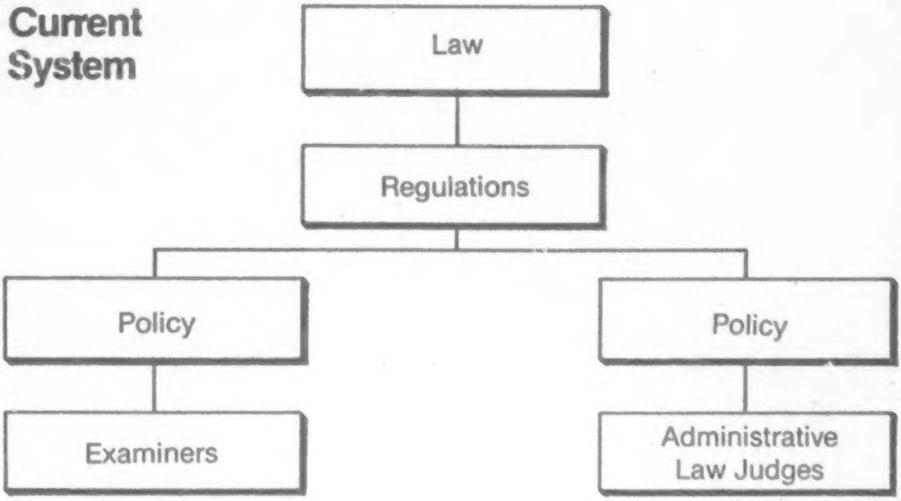


Tenacity is eventually rewarded in the current disability adjudication process. Of claims consistently denied at lower levels, a majority are reversed at the administrative law level. The reason: a different set of criteria is used at this level, effectively contradicting the basis for prior decisions.

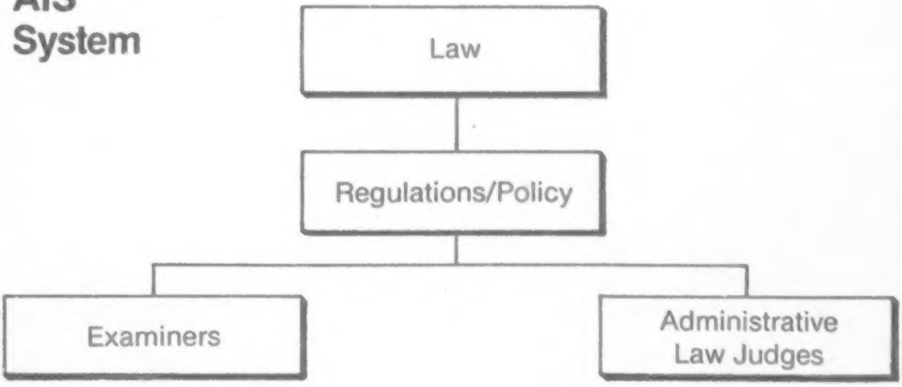
*Figures are for the year 1981, during which there was an average of 22,500 disability-related hearing requests per month nationwide.

Proposed Changes In Considering Vocational Factors

Current System


Law
Regulations
Policy
Policy
Examiners
Administrative Law Judges

AIS System


Law
Regulations/Policy
Examiners
Administrative Law Judges

Determining A Person's Ability To Engage In Substantial Gainful Activity (S.G.A.)

1) Handicap + Ability = Residual Functional Capacity (R.F.C.)

2) R.F.C. is Correlated to Existing Jobs

3) A determination is made of a person's ability to engage in Substantial Gainful Activity

The AIS System

AIS Computer:

1) finds job descriptions and profiles relating to prior work experiences, and summarizes if there are two or more,
2) prepares worker profile which reflects disabilities,
3) searches and finds all relevant job codes and logically eliminates inappropriate ones,
4) gives list of all relevant job codes,
5) correlates with regional job bank information to find which jobs actually exist in the region of residence.

In a total of 15 minutes, the AIS System performs tasks which might have taken a lifetime to perform manually. This thoroughness and the rapidity of its operation make it a tool for the achievement of our highest goals: prompt payments to those who are truly disabled; supportive counseling for partially disabled; equitable use of taxpayers' money.

Chairman PICKLE. Well, Mr. Watters, you have presented a new approach, as far as the chairman is concerned. I assume that you have talked with various agencies about this proposal. Have you talked to the SSA offices in Baltimore, or here?

Mr. WATTERS. Yes, sir.

Chairman PICKLE. What is their reaction to this type of a proposal?

Mr. WATTERS. The reaction of various people in the Social Security Administration structure has varied considerably. I have actually something that I would like for you to enter into the record. At the suggestion of Congressman Rousselot and myself, I would like to ask permission that a prepared statement by a Judge Barry Wesker, Administrative Law Judge in charge of the Pasadena Office of Hearings and Appeals and Director of Region 9 of the Association of Administrative Law Judges, be inserted into the record immediately following my statement.

Chairman PICKLE. That will be—would you like that part of the record, Mr. Rousselot?

Mr. ROUSSELOT. That sounds pretty good to me.

Chairman PICKLE. It will be included.

[The statement of Judge Wesker follows:]

STATEMENT OF BARRY M. WESKER, ADMINISTRATIVE LAW JUDGE, PASADENA, CALIF.

Mr. Chairman Pickle, Congressman Rousselot and members of the Committee, I thank you for the opportunity to present written testimony in support of Congressman Rousselot's amendment to the Disability Amendments of 1982.

My name is Barry M. Wesker. I am the Administrative Law Judge in Charge of the Pasadena Office of Hearings and Appeals and am the Director of Region IX (California, Arizona, and Hawaii) of the Association of Administrative Law Judges in DHHS. However, I must make clear that the following statement is offered as a private citizen and individual Administrative Law Judge, and not in either of the above named capacities. I write specifically in support of Congressman Rousselot's amendment to the Disability Amendments of 1982 and my statement is referrable only to that amendment.

After 8 years as an Administrative Law Judge, I naturally have developed certain opinions based on my own experience and now address those issues which are of growing concern to an Administrative Law Judge interested in the continued improvement of our adjudicative process.

I believe that Congressman Rousselot's amendment would provide a viable method by which the following results can obtain:

(1) Informational retrieval systems as contemplated will permit State Agency Disability Examiners to make more accurate individual assessments of a claimant's vocational capabilities. Uniformity and consistency will be achieved in a cost-effective manner, via immediate access to up-to-date vocational data, available on demand from acknowledged experts from the private sector, whose performance will be "honed" by the necessity for competitive excellence;

(2) The contemplated system will permit lower level adjudicators to compile better records as cases proceed to OHA. At present, most cases that reach the Office of Hearings and Appeals are bereft of meaningful vocational data. Improved quality of vocational data obtained through the utilization of the proposed system will permit more efficient case handling at the OHA level;

(3) The potential for disabled beneficiaries to return to the work force is enhanced by realistic vocational rehabilitation analysis. Accurate and meaningful assessments of the recipient's vocational "profile," coupled with a current picture of the labor market, allows the Secretary to guide the recipient to proper vocational rehabilitation, trial work periods, and ultimately a return to the work force. At the hearing level, this goal can be implemented in two stages:

(A) Administrative Law Judge encouragement of medical remediability through the extension of the "conditioned award" concept (tying the award of benefits to the effort of the claimant to follow prescribed medical treatment) as first enunciated by the Secretary in alcoholic and drug addiction cases;

(B) Awards "conditioned" on concurrent vocational rehabilitation efforts with private sector involvement in rehabilitation guidance, encourages claimants to use benefits to help hasten their return to the work force;

(4) Hard-headed positive encouragement in areas of medical remediability and accurate vocational data will clearly place the onus of responsibility for improvement on the individual claimant, thus reinforcing the "work ethic";

(5) Failure to follow recommended "treatment" (medical and vocational) would support termination of the benefits, thereby "protecting" the fisc from abuse;

(6) Economic productivity factors are enhanced by additional "workers" entering other areas of the work force after successful rehabilitation;

(7) Use of administrative notice at the hearing level, permitting particularized proof applicable to individual claimant capabilities, or use of vocational expert testimony where deemed necessary, is immeasurably improved by the immediate availability of up-to-date vocational data to the Administrative Law Judge. This important additional factor helps create a "standard," or qualitative minimum criteria, by which Administrative Law Judges can evaluate vocational experts with more fairness and validity;

(8) Hearing records will contain less error, resulting in better quality and consistency, therefore resulting in fewer remands, and significant cost savings to OHA and SSA.

In summary, the enormous and ever-increasing "job-gap" problem created by the removal from the work force of those who have been rendered unfit for work efforts because of well-established physical and/or emotional disabilities, now require new and better use of modern and efficient methodologies, to reawaken a new era of "work ethic" motivation.

Congressman Rousselot's amendment presents a "window" by which our future efforts may be seen in the light of their potential ameliorative effects. I heartily endorse this concept and herewith offer, subject to Administration approval, the Pasadena Office of Hearings and Appeals facility as a "test" facility.

Thank you for the opportunity to offer my comments.

Mr. WATTERS. Also, I have been working on this issue for a number of years and have had contact with people in State disability adjudication processes, the Social Security Administration on various different levels, and I have had mixed reactions. I have had the reaction that people who have designed workings of the system trying to eliminate vocational factors from consideration who oppose it. I have had people in other areas support it. I have had very mixed reactions from within the administration.

From the people on the Hill who I have made presentations to in the staff of both the minority and majority side of Senate Finance, and the Social Security Subcommittee, I believe I have had a quite favorable response.

Chairman PICKLE. Well, I will talk with our staff and other members of the committee. I have some questions about it. I like the modernization of it. I have an immediate reaction that you are trying to match a person's disability or not with a job that might be available. I want to be certain that he is disabled first, and then look for a job to try to combine disability and employment, or the availability of the job. But there again, I do not want to say that is how it would work. I do think it is worthy of discussion.

What you are asking for is a kind of a pilot test with some State agencies to see whether it is the type of thing that would be workable? Is that what you are saying?

Mr. WATTERS. That is correct, Mr. Chairman.

Chairman PICKLE. Do you have any idea about the expense of it?

Mr. WATTERS. I believe that it would cost somewhere, for the hardware, software, staffing, and taking about a 20th of the country, it would cost approximately $1,750,000 to do that.

Chairman PICKLE. Are you the Ability Information System? Is that your company?

Mr. WATTERS. Right. I am one of the founders of the company. The company was actually formed inadvertently by a letter from you. [Laughter.]

Chairman PICKLE. I believe that is an accurate statement.

Mr. WATTERS. Back 2 years ago I wrote your office a letter and mentioned this factor to them and I was assured that that was something that was worth looking at. I was referred to somebody in Washington State who had looked at this issue a few years ago. Based upon that, we formed an agreement, and we got private investors to support the concept of cleaning up the system in this kind of a way.

Chairman PICKLE. Well, you have given us a very definite proposal and it is very interesting. We will look into it.

Mr. WATTERS. Thank you, Mr. Chairman.

Now, Mr. Harris——

Mr. ROUSSELOT. Mr. Chairman, I will have some questions, but I will wait until the other gentleman testifies.

Chairman PICKLE. All right. Mr. Harris——

Mr. ROUSSELOT. I do have some questions of this gentleman.

Chairman PICKLE. Is your testimony related to his?

Mr. HARRIS. No, it is not. I think perhaps you would be better advised——

Chairman PICKLE. Why do you not go ahead and ask your questions now, then.

Mr. ROUSSELOT. All right. Well, I certainly do not want to slow down your testimony.

Mr. HARRIS. No.

Chairman PICKLE. Mister——

Mr. ROUSSELOT. Mr. Chairman—Your Honor. Excuse me.

First of all, thank you, Mr. Watters, for being here to testify. You probably recall, Mr. Chairman, that he submitted testimony before our subcommittee in May of 1981 on a similar subject, and it is a part of the record of 1981.

I think it is interesting that much of what Mr. Watters has done has been triggered by your original letter 2 years ago. So you never know what you start when you write a letter, Mr. Chairman.

Chairman PICKLE. Or when I recognize somebody.

Mr. ROUSSELOT. Right. [Laughter.]

And I am also pleased that you have submitted the additional statement of the administrative law judge from Pasadena, Calif., which happens to be a terrific place to live.

Mr. WATTERS. So I have heard.

Mr. ROUSSELOT. It is in my district, as you know. I think it is a positive addition.

Let me ask you a couple of questions. I think you have summarized very well in your conclusion what you believe this system could do for the disability program.

And by the way, Mr. Chairman, Congressman Chaffe of California was one of the ones who encouraged Mr. Watters to come to our committee. I thought you should know that.

Will not your proposal interfere with the mandate of the law to make individual determinations?

Mr. WATTERS. Quite the contrary. At this point, rational shortcuts are necessitated by the volume of data that has to be handled by the disability examiners, the disability adjudicators on all levels. And it will provide a management tool to handle that data on an effective basis. To give you a real quick picture of that, there are millions of people——

Mr. ROUSSELOT. So you think it enhances individual determinations?

Mr. WATTERS. It certainly does.

Mr. ROUSSELOT. All right. Go ahead with your example, because I am sure the chairman will want to hear this.

Mr. WATTERS. The relationship of the variables to the Dictionary of Occupational Titles to look at the physical possibilities of search in those variables, there are 1,400,000 search possibilities.

Mr. ROUSSELOT. A million what?

Mr. WATTERS. 1,400,000 physical search possibilities in the relationship of one vocational profile to the Dictionary of Occupational Titles. The system can process that in 1 to 5 minutes.

Mr. ROUSSELOT. Now where will the financial savings be realized in your proposed system?

Mr. WATTERS. I am proposing that the system be implemented on the administrative law level, and in the initial and reconsideration levels as a stardard for consideration in vocational factors. There are various statements that have been made about the appeals process and the 61-percent reversal rate at the administrative law level, et cetera, but it is clear to everyone that a large percentage of those cases that go to administrative law court are dealing with vocational factors. Roughly 80 percent is an estimate that I have——

Mr. ROUSSELOT. Eighty percent?

Mr. WATTERS. Eighty percent of the cases that are appealed to administrative law court are appealed on the basis of vocational factors. I have gotten that as an estimated statement from various administrative law judges.

Mr. ROUSSELOT. That is your educated guess?

Mr. WATTERS. Yes.

Mr. ROUSSELOT. How can your system be used to eliminate inappropriate benefit payments?

Mr. WATTERS. It brings back the mandate of the law to look at the ability to engage in substantial gainful activity at the baseline once you have established severe physical or mental disability. The more we move away from that base to strictly in factor of medical factors as a determination of eligibility but in combination with vocational considerations, when we are clearly looking at objective factors in relationship as to whether or not somebody can do work and where those jobs exist—not "are available" but "exist"—in significant number in the economy. That is when we start to approximate the meaning of the law, and that is what this system provides.

Mr. ROUSSELOT. Does your system solve the problem of determining residual functional capacity?

Mr. WATTERS. It does not. It is not a panacea. It is not a solution to the myriad of problems that are facing this subcommittee. It is a solution to one specific problem. And once you get that residual functional capacity, what does it interface to? It interfaces to the world of existent jobs. And that is what this works at to solve.

Mr. ROUSSELOT. Now by what authority are the data bases used in your system applicable to the decision of whether or not the job exists?

Mr. WATTERS. By the authority of the Secretary of Health and Human Services. The documents that I put within the data base structures are all taken under administrative notice by the Secretary as authoritative guides in this area. They include such things as the Dictionary of Occupational Titles, the County Business Patterns and Structures, the format of the Handbook for Analyzing Jobs, et cetera.

Mr. ROUSSELOT. So your proposal will indicate whether or not a job exists?

Mr. WATTERS. Yes.

Mr. ROUSSELOT. Is that by region?

Mr. WATTERS. There is the possibility of a regionalized output. That is true.

Mr. ROUSSELOT. Now as I understand it, you have proposed that we do this on a demonstration basis. By region?

Mr. WATTERS. I believe that that would be advisable.

Mr. ROUSSELOT. Say five demonstration projects——

Mr. WATTERS. Yes. I was thinking——

Mr. ROUSSELOT [continuing]. To start up?

Mr. WATTERS. I think that that is a reasonable approach. I believe that you need a large enough sample to really test the possible individual differences that may enter between or among administrative law offices. You need—I believe it should be performed in one State, and preferably a large State, for the reason that State politics regarding disability adjudication will be neutralized. And you can also slip the State and perform the control group study, as well as an experimental group where you try to get the approximate.

Mr. ROUSSELOT. Well, thank you, Mr. Watters. We appreciate again your being with us to explain your system.

Mr. Chairman, I have additional questions which I would like to ask, but from which I will refrain from doing, which can be submitted.

Mr. WATTERS. Thank you, Mr. Rousselot. That will be fine.

[The following was subsequently received:]

CONGRESSMAN JOHN H. ROUSSELOT'S QUESTIONS REGARDING GEORGE M. WATTERS' TESTIMONY

1. From your testimony you indicate that your proposal allows for the consideration of 122 variables in an individual's ability profile and that it can do a search for jobs that the individual may perform in about 15 minutes that would otherwise take a vocational expert hours, days or sometimes even months. Describe some of the variables considered.

2. How does the disabled beneficiary population or the applicant to the Disability Insurance program benefit from your system?

3. Won't your proposal interfere with the mandate of the law to make individual determinations?

4. Where will the financial savings be realized from your proposal system?

5. Does the process included in your system follow existing law and regulations?

6. Does your system replace the "grids" or vocational rules required by the regulations?

7. How can your process be used in continuing disability investigations?

8. What information and authority is used in your databases to assist in the decision of whether or not jobs exist?

9. How do you know your system will work?

10. So your proposal has the capability to indicate whether or not jobs exist in a particular region where a beneficiary or applicant may reside?

11. Will your system eliminate benefit payments to any groups of people who are unable to work because of disability?

12. Doesn't this take away from the examiners or judge's ability to weigh factors in the decision process?

13. How can your system be used to eliminate inappropriate benefit payments?

14. How does your system handle the determination of residual functional capacity?

15. Will your system improve procedures for considering vocational factors related to mental disability?

16. Won't your system add more paper work to the disability process?

17. Does your system eliminate favorable decisions made solely on the basis of severe disability—the medical listings.

18. Does your system allow for consideration of advanced age as mandated by the regulations, for determining what skills a person can transfer from his/her work history?

George Watters' Answers to Congressman John Rousselot's Questions

1. Some of the variables considered by the system include: Education, Physical Demands, Temperaments, Aptitudes, and Training Requirements. These considerations are further refined to include numerical skill acquired to perform jobs, motor coordination, spatial perception, adaptability to performing repetitive work, medically restricted interest areas, climbing, talking, vision, to name a few. The system evaluates all worker trait characteristics utilized by the Department of Labor in their analysis of jobs.

2. I see several ways in which disabled beneficiaries and applicants to the Disability Insurance program will benefit by the proposed system. It reduces arbitrary consideration of many factors essential to fair decisions. It provides for rapid consideration of cases formerly delayed for months in costly appeals processes. And from disability determination information, it provides the basis for rehabilitation planning.

3. No, quite the contrary! The system enchance individual determination. Presently, information must be neglected by adjudicators and experts because it is manually exhaustive to consider all the variables. By providing a more comprehensive and rapid evaluation, the system enhances the ability to consider each case individually.

4. Administrative costs will decrease significantly. (It is currently estimated that the people awarded benefits at the administrative law level require administrative expense in excess of the people awarded at initial and reconsideration levels combined—in spite of the fact that less than 26 percent of allowances are made at the A.L.J. level.) Inappropriate benefit payments can be halted to those people who are able to perform jobs that exist but have not previously been identified.

5. The processes within the system are fully compatible with existing law and regulations. The information accessed by the system is more thoroughly in accordance with the regulations than is the data available from current manual techniques. The proposed system will also be able to handle cases in a more precise and rapid manner.

6. No. The system has been programmed to be fully compatible with the Social Security Administration's vocational regulations. Therefore each logical step taken under consideration by the "grids" can be performed automatically when residual functional capacity (age, education and work experience) is entered for consideration.

7. In two ways: (1) Accurate information regarding vocational factors is essential in cessation cases. The burden of proof is on the Secretary of Health and Human Services to provide evidence that jobs exist which a beneficiary can perform. The process provides such evidence when appropriate.

(2) It is suggested that the system be used to study continuing disability investigation (C.D.I.) cessation during the pilot study. Profile characteristics will be compared as follows: Those terminated claimants who are successful in appeal will be compared with those who did not appeal and those who were unsuccessful in appeal. It is anticipated that such a study would provide the basis for future C.D.I.'s to be based upon substantial gainful activity potential, thus eliminating excessive C.D.I. reversal at the ALJ level.

8. The information used in the database structure is taken under administrative notice by the Secretary of Health and Human Services as authoritative for disability adjudication. The system is capable of incorporating and relating the following

documents: the Dictionary of Occupational Titles (published by the Department of Labor), County Business Patterns (published by the Bureau of the Census), Census Reports (also published by the Bureau of the Census), and Occupational Analyses (prepared for the Social Security Administration by various sources including State employment agencies), and Occupational Outlook Handbook (published by the Bureau of Labor Statistics). (Reference 20—CFR 404.1566.)

9. Because it works now. In fact, it has successfully been applied to several real life cases. In addition, March 29th is the date set for our first official display of a system designed to assist in placement, adjudication and rehabilitation.

10. Yes—by use of county business patterns and employer listings.

11. No, the system does not evaluate cases by groups. The system assesses the relationship between the functional capacity of disabled individuals and jobs that exist. It therefore approaches with greater accuracy the definition of disability mandated by law.

12. No. It makes both judges and examiners accountable to a common standard regarding vocational information. The standard is based upon the regulations and is regionalized in accordance with the rulings.

13. After study, continuing disability investigation could be conducted based upon vocational profiles after application of medical criteria. This allows for a more precise evaluation of the ability to engage in substantial gainful activity. (The proposed pilot study could analyze dissallowed cases to identify common vocational patterns and the relationship of those patterns to successful appeal.)

14. The system would not change existing determination of RFC (Residual Functional Capacity). However, it would improve upon present methods by establishing a frame of reference in which to collect that data. This is especially true in mental, sensory and skin impairments, and some postural and manipulative limitations restrictions. In contrast, the current system applies a highly subjective method of relating functional limitations to the ability to work.

15. Yes. For the first time it will be possible to relate the limitations pursuant to mental conditions of the specific temperament and interest demands of work. Currently, less objectivity and uniformity is applied in adjudicating mental disability cases than with physical disability cases.

16. No. The system will decrease paper work.

17. No. The system is designed to consider vocational factors and the existence of jobs only.

18. Yes. The system does comply with the regulations in this regard. (Example: 20 Code of Federal Regulations (400-499) Appendix 1, Section 200F. The system tightens consideration of the precise factors enumerated in this section.)

Mr. SHANNON [presiding]. I do not have any questions. I am sorry I was not here for your testimony, Mr. Watters. From what I have been able to pick up from Mr. Rousselot's questions and the chairman's questions, I think your proposal is a very interesting one. I will read the testimony and perhaps I will be in touch with you myself.

Mr. WATTERS. Thank you.

Mr. SHANNON. Thank you, Mr. Watters.

STATEMENT OF JOHN HARRIS, PRESIDENT, NATIONAL COUNCIL OF SOCIAL SECURITY FIELD OFFICE LOCALS, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Mr. SHANNON. Our next witness is John Harris, the president of the National Council of Social Security Field Office Locals, American Federation of Government Employees. Mr. Harris, your full testimony will be entered into the record, if you want to summarize it.

Mr. HARRIS. If you can hear me, I will just speak without the microphone.

Mr. SHANNON. Why do you not just pull Mr. Watters' microphone over?

Mr. **Harris**. This document that I have provided you, most of it are exhibits. I am going to be calling your attention to those exhibits particularly now with my comments.

What I want to say first of all is that I find myself having a very difficult task. I want to change your point of view about this disability problem, and I am not sure I will be able to.

Mr. Rousselot, for example, I understand has had strong feelings that there are many people on disability who should not be on disability. I know you have concerns about the high variances in the State agency allowance rates.

I know that you, Mr. Shannon, and I know the chairman, have been exceedingly concerned about the mismanagement of the disability program. You have become de facto commissioners of the administration, which I hope you will not have to do for too much longer.

What I want to tell you, though, is that the fact that there may or may not be too many people on disability is overshadowed by the fact that we in SSA do not really know what a "disability" is. We became alarmed by the large allowance rates in the mid-1970's. We became alarmed because the Social Security Administration ceased doing medical reexaminations. They cut down on doing continuing disability investigations, and we assumed therefore that there were probably people getting on the rolls that should not be.

There was then a study by GAO, which you all have seen, which suggested that perhaps 20 percent of the people on the rolls should not be on the rolls. The problem with that study was there was no real medical review conducted to make that judgment. It was merely a review of what was in the file.

Social security has since that time done some reviews, and there are some significant things that must be said. Yes, Mr. Rousselot, you are correct that there are some people on the rolls who should not be. They are in some very interesting areas. They are in areas especially where there have been medical science improvements—some cardiac cases where, because of bypass surgery people are recovering and they are not experiencing angina; in cases involving cancer, for example, Hodgkins disease, leukemia. But the Social Security Administration in doing that study are also telling to you that people that they used to allow for psychiatric listings, or mental listings, or other listings, are not disabled.

Now when we reviewed this situation what we found was that SSA has changed its rules. Not because of any objective basis. The disability regulations that they use have never been validated. They have never tested them against medical science and vocational rehabilitation.

The Social Security Administration has never asked itself what happens to those we disallow. We have some sketchy data. They did one report in 1979 in which it was found that only one-tenth, 10 percent of the people that are disallowed benefits ever go back to substantial gainful activity.

We also know that those people have high mortality rates. There was then too a study in the 1960's in which SSA found that most people never return to substantial gainful activity. That limited study also showed that the family income of those disallowed was lower than the family income of those who were allowed. Hence, the spectre of poverty; hence, the spectre of dependence on State and local government.

What I have concluded is that SSA really does not know that the ones disallowed benefits are not disabled. Now the hardship that this is creating, you have heard some testimony to. In the exhibits I have given you I take two recent cases of individuals who have been ceased from benefits in St. Paul, Minn.

These individuals have released these documents to me through their lawyer. I have nevertheless struck their surnames and their social security numbers.

In one of the cases, the case of Charles, the Social Security Administration started their review in May. He was in fact hospitalized for 11 days in May. He subsequently was rehospitalized for 32 days in August and September; 6 days again in October.

In November the Social Security Administration ceased his benefits. Reading from their statement to him they said:

> You were originally found disabled due to an emotional disorder and seizures. You said you still have seizures and have been hearing voices for about 2½ years. Your seizure disorder is under fairly good control with your last seizure occurring four or five months ago. You are able to interact well with other people. You have several activities and interests. There are signs you do hear voices, but they do not severely affect your ability to function. You are able to take care of your own needs and, although you have never worked very long, we conclude that you are now able to do simple unskilled jobs.

Eleven days after that, November 15, he was admitted again to the phychiatric ward of St. Paul-Ramsey Hospital, the local county hospital. The medical report is attached to the exhibit. He had threatened to kill himself by stabbing himself with a knife. He was hearing voices that were telling him to do that.

This, I want to say, is exemplary of cases like it all over the country. My people, the workers that I represent, come from all over. We represent all of California, Mr. Rousselot; and we represent all of Massachusetts. They report to me that these are the kinds of things they are seeing daily in their offices.

The other example, the example of Karen, is a girl who came on the rolls in social security in 1968 because of mental retardation. SSA conducted a continuing disability investigation on her recently. She was one of the cases known as a "profile CDI." A "profile CDI" was developed based on data that I have cited to you showing high levels of so-called ineligibilities among the mentally impaired.

This use of profiles is one of the reasons why you are seeing high incidents of cessations on those mentally retarded and mentally ill right now; SSA is deliberately seeking out those cases to conduct investigations on them.

In Karen's case SSA stated:

> Medical records now show the applicant's intelligence is above the level that in itself is felt to constitute disability.

She had an IQ of approximately 63, and the cutoff point is 59.

> There is no evidence of a physical or emotional problem at that——

And it is confused language; I assume it means at the present time——

> That presents additional restrictions. The claimant is able to interact well with other people. There is no current evidence of a major thought disorder. She presents an adequate personal appearance and appears able to take care of her own needs.

> There is no indication that seizures are currently a problem. She can remember, understand, and carry out instructions and procedures, and she can respond appropriately to work pressures and supervisions. She is able to meet the basic demands of unskilled work.

So it is written.

It is based on the medical evidence of a Dr. Flynn, a Dr. Diessner, and a Dr. Richardson. Attached to these exhibits are the reports of Dr. Flynn, and Dr. Richardson. Dr. Richardson's report says, in part:

> The client was painstakingly slow in her finger/visual/motor reactions and seemingly unaccustomed to clerical routines.

It goes on to say:

> I would describe her current level of functioning as below the sheltered workshop norms, more like that of a dependent, inadequate personality type and an individual who is more severely retarded and in need of work activity center programming.

Dr. Flynn goes on to say:

> We have a patient here who has a several year history of mental illness with acute psychotic breakdowns. This is well confirmed and apparently her treating psychiatrist at this time believes that she has to be maintained on tranquilizing drugs. The patient also has a history of seizures and again her treating doctor believes that the patient requires Dilantin to help her to control seizures. The patient is extremely simple, naive and apparently is retarded, but probably in the educable range of retardation. She is obviously a very dependent person and I doubt that she can manage her own money. I doubt that this person would be able to work in anything but the most unskilled of labor and in a highly supervised setting, probably a sheltered workshop.

The third exhibit is a copy of an internal memorandum from Social Security that reflects the internal dispute about this problem. The Administration is increasingly narrowing its interpretation by saying: "If a person does not meet the listings exactly, they do have the capacity to work, by definition. And that is demonstrated by the fact that"—and I kid you not; this is in some of these reports—"they are able to dress themselves, they are capable of watching television, they can take a bus, and thus they are capable of working."

Now it is not really my purpose to be here as an advocate on behalf of the mentally retarded and mentally ill, even though as workers that try to help these people with benefits we feel strongly about these people. What I am trying to do is to illustrate for you that the disability regulations that we are working with are not valid, or are very dubious; and that the medical community, the vocational rehabilitation community, holds no stock in them.

What does that mean in terms of H.R. 5700? It means that you cannot reasonably say that the administrative law judges are making wrong decisions, any more than you can say that the State agencies are making the right ones. It puts you in a very difficult position.

It means something else, too. It means that over the next 3 years as we commence to have more and more of these CDI's, these tragedies that we have been talking about, the suicides, these people being cut off rolls and thrown in the State hospitals, and going into locked wards, et cetera, are going to increase and multiply. It is a very frightening prospect.

Just simply to close out—and if you would like me to comment on the bill in particular I would be glad to—but I would suggest this: I know it is a departure from where you have been, but you have created—or we have created—a monster here with these CDI's, and with the new climate of adjudication. I think that we had better tranquilize this monster and conduct some surgery on it. What I mean specifically, then, is I suspect you must have a moratorium on these CDI's for a period of time so that your Advisory Council on Medical Disability could do serious investigation and test, validate, and promulgate corrected, proper medical listings. That is really it. I hope it is of some value.

[The prepared statement with attachments follow:]

STATEMENT OF JOHN HARRIS, PRESIDENT, NATIONAL COUNCIL OF SSA FIELD OFFICE LOCALS, AFGE, AFL-CIO

Mr. Chairman, my name is John Harris and I am president of the National Council of Social Security Field Office Locals, an affiliate of the American Federation of Government Employees, AFL-CIO. Since 1979 my union has held exclusive recognition for 72,000 Social Security workers nationwide; the national organization of which I am president represents about half of those—employees of some 1,300 district and branch offices and teleservice centers across the nation and in Puerto Rico.

I am here today to express some of the feelings and observations of my membership, those who daily administer the Social Security program. We offer you a unique viewpoint. First, what we know is based not merely on the dry stuff of statistics and reports but also on the human presence of the client whom we serve. Second, we have an unusual dual responsibility in our work that gives us a perspective at once professional and humane. For while we must administer rules and regulations in accordance with Social Security dictates, we also serve to help the clients in our offices and their lives touch us and we care. We are both benefactor and arbiter and we see problems—like this one of the disability program—with a profound mixture of feelings and observations.

We are alarmed by the precipitous decline in state-agency allowances in the disability program and we find many of those decisions unfair. We are alarmed by the sudden increase in cessations of those on disability—many of whom we know to be unfit for work from our personal observation—and we have concluded that this change is the result of a cynical and political motive to cut the roles of disability and is not sound in principle. But we are also concerned about large numbers of beneficiaries who are currently enrolled who should not be enrolled. We are receiving extraordinarily high numbers of reports of fraud—of the disabled working, of the disabled without severe conditions—and we feel the program was long over neglected and lacked effective quality assurance. We are finding a large number of cases in which the disabled have not reported work activity and because the SSA system of wage reporting is so poor, we are years behind in detecting work activity. Even now work activity from as long ago as 1978 is going undetected.

From our point of view the disability program seems badly mismanaged and disability determinations seem arbitrary and capricious. We witness variances in determinations between the states that are still wide and unexplained. In one state those officially disabled number 2,000 per million; in another they number 40,000 per million. It is said that in some states you must be dying or dead to be allowed and in another examiners are exceedingly more liberal. In spite of efforts to bring uniformity and consistency to the program there is still today the spectacle that what is found a disability in one state is not found a disability in another, and the emphasis of quality assurance goes not to what is a proper determination, so much as to restrictions and restraints on allowances in order to keep them down. To the examiner he errs not by disallowing somebody's claim; error is only found in allowing. So the examiner is hesitant and niggardly in his evaluations and benefits of doubt go against the claimant. Finally we see the extremely high disagreement between ALJ's at the hearings level and the state agencies; better than 60 percent of state agency decisions are reversed by ALJ's. We reject the idea that either ALJ's or state agencies are behaving in bad faith. Rather we see these circumstances begging the question: do we really know what a disability is? Do we really have a fair and equitable definition of disability?

As you are aware the definition of disability in the Social Security Act is a general statement and the amplification of that definition is the subject of regulations and procedures. One would assume that the regulations and procedures are objectively derived, based on real program experience, medical science and professional judgments of vocational rehabilitation. One would assume, then, that those who are disallowed, given some reasonable expectation for accuracy, that those disallowed are truly not disabled under the Statute and therefore their impairments terminate and/or they go back to work. In fact, neither of these things seem true. Although the data is sketchy, it appears that the vast majority of those disallowed disability benefits never go back to work, and most report their medical condition is the same or worse. The most recent study by SSA shows that perhaps only 10 percent ever return to substantial gainful activity.

Now we say that this data is sketchy because it turns out that SSA has never asked itself what happens to those people they disallow. And we've also found that, in that context, SSA has never asked itself whether its definition of disability is really correct.

The lack of continuing review and study on the definition of disability is one of the reasons that we now see some people on the rolls who are medically recovered. This alone constitutes at least one-third of the body of people allegedly ineligible who are now getting benefits. The regulations and procedures have historically lagged behind advancements of medical science, and there is no current mechanism to assuage this. Moreover, there has been no technical validation of the current regulations in terms of their reliability as medical science or principles of vocational rehabilitation. What does this mean in the context of these hearings? It means that the program is in such a state that you must expect both the evil that truly disabled people are being denied benefits unfairly and that fit people are being awarded benefits. It also means that you can't reasonably assess either the validity of state agency performance or the seeming impropriety of ALJ decisions.

Now I want to fairly warn you that even given improved mechanisms for determining disability you will never eliminate the essential subjective quality of those determinations. You cannot do fairly and equitably what SSA has tried to do—to make of the regulations an exact science or to make of vocational listings an inflexible "grid" of coefficients. Even in their current efforts SSA acknowledges a disagreement rate among their reviewers of 21 percent—that is, disputes about whether a claimant is disabled. It is for that reason especially that we have an appeals system. And it is imperative that the integrity of that system be preserved. There must be an independent and less regulated judgment available at the hearings level and I fear that some of the proposals before you should undermine that if they were enacted.

We share the concerns among you that the apparent divergence between state agencies and ALJ's is far too great. But we do not think the cause of that problem or the solution lies really with them. Moreover, we think that a balanced analysis would show not that ALJ's should become like the state agencies nor that the state agencies become like the ALJ's, but that both must move closer to each other. To do this we need a management of the program which is much more competent and effective that it has been for over a decade. For when you search back to find the origin of all our current problems, you will find it is SSA's sometimes deliberate, sometimes negligent actions or failures to act.

In a nutshell, the people on the rolls today who should not be on the rolls are the consequence of poor quality assurance, inadequate training and staffing, ill advised expedients, insufficient regulations and procedures, and in general the failure to act on problems when they arose. And the people who are now disallowed and ceased from benefits who should get benefits are the victims of equally incompetent management initiatives to recover their failures in a zealous program to cut the rolls without regard to human consequences.

I have testified before that you cannot legislate good management. And yet you cannot shirk your responsibility in the Congressional branch by deferring utterly to the Executive. It is a quandry of modern government and, while we have some ideas on how to help resolve it, that is not here and now our purpose. Nevertheless, there are some immediate steps that you can take and we offer them below.

PROTECT THE TRULY DISABLED

In the present administration of the program Congress must recognize the serious jeopardy of innocent beneficiaries—those who are victims of changed regulations, those who are victims of unfair determinations. While the procedures for CDI's and medical reexaminations will improve, now and even in the future people will be wrongly denied the benefits they depend on. Therefore, you should enact provisions that permit appealants to keep their benefits through the appeals process, and, in order to avoid complications of the recoupment of these funds, should the appeals be denied, the beneficiary should not be required to repay these benefits it would defeat the purpose of Title II to do so. In addition you should mandate that cessations of disability based on medical determinations should be prospective and never retroactive absent evidence that the beneficiary willfully withheld reporting a significant medical improvement which clearly made him ineligible. SSA—in its recent initiatives—has started a practice of retroactive terminations that is especially onerous and unfair given the very questionable disability program.

IMPROVE THE APPEALS PROCESS

Procedures such as those in S-2086, currently pending, in which the disabled are given some advance notice and opportunity to provide medical evidence in CDI's is to be highly recommended. It not only is fair, it may save us some expense in the processing of such cases by obviating the need for consultative examinations.

Toward some immediate efforts to enhance the credibility of ALJ determinations, we should fund and establish resident medical advisers in OHA field offices to assist in medical judgments for which ALJ's are largely untrained. The curent procedures of seeking ad hoc advise by contract is time consuming and inefficient and deters its own use. In addition, training of ALJ's is woefully inadequate; it is shorter than similar training for SSA employees and is not reinforced or enhanced with the same professional system as SSA's general training program. Finally, recognizing the difficulty in recruiting ALJ's, SSA should develop and pilot a career examiner program, whereby staff attorneys with as little as 2 to 4 years of legal experience can progress through a career ladder of planned development, ultimately to graduate to ALJ positions. A program such as this would reinforce the objective of bringing ALJ determinations more in line with SSA regulation and procedures, while preserving their essential independence and integrity.

ENCOURAGE VOCATIONAL REHABILITATION AND WORK

Increased funding and improvements in vocational rehabilitation such as now proposed are essential. But we fear that the program will suffer from the impediments that have always obstructed it in the past. Namely, VR agencies are discouraged from assisting the severely disabled because those cases are difficult, laborious, and costly, and funding has been tied not to effort but to "success." Quite simply VR agencies are already so overburdened with caseloads involving the less than severly disabled that they cannot effectively deal with those of SSI or SSDI rolls. Enactment of targeted VR programs for clients with above-average potential for rehabilitation (based on age and medical condition) and sufficient regulatory and administrative controls to ensure the focus of these targets is the only way that even modest funding can get some reasonable return for its investment.

Finally, the SGA provision of Title II is a disincentive for both VR programs and work activity. While many of the disabled are marginally employable and some capable of ultimately returning to full employment, the statutory concept of SGA inhibits work activity and may in fact encourage unreported work activity. We endorse the use of an earnings test similar to that for retirees with provision for periodic medical reviews where work activity is sustained above certain levels or over certain periods of time.

VALIDATE AND PERIODICALLY REVIEW THE DEFINITION OF DISABILITY AS SET FORTH IN THE REGULATIONS

The interests of no one are served by a program whose basic eligibility criteria are as widely criticized and in doubt as this one. Neither the Congress, the public, nor the professionals of medicine and vocational rehabilitation are satisfied with the current procedures. The lack of confidence alone seems good cause for this action; but larger questions of equity and administrative integrity demand that Congress should empower a commission to review, validate and promulgate new disability regulations. On such a commission the expertise of medical science and vocational rehabilitation should be prominent and SSA should play its particular role in assessing and acting upon the administrative impact of the commission. Congress should further provide that SSA must regularly and periodically review and report upon the validity of such regulations and subject such future changes as are necessary to the scrutiny of such independent expertise as represented by this special commission.

IMPROVE ADMINISTRATION OF THE DISABILITY PROGRAM

If we continue to manage the federal government from the point of view that across-the-board cuts and staffing ceilings are the way to root out inefficiency and waste, we will continue to be victimized by situations like this—the deterioration of program administration resulting in poor public service and overpayments. There is nothing so wasteful as meat axe economics. The expedients we have adopted and continue to adopt in the name of the taxpayer are robbing the taxpayer of services he asks for and the benefits he pays for.

As a union we have this timely manifesto: we can make government more efficient and more effective if you would only listen to us. As it is, the worker is attacked and maligned both in the government and out. But I submit he and he alone knows how this government works or fails to work and ultimately you will need him.

SUMMARY

Attached are documents to illustrate the problem of disability cessations and in general the increasingly unfair application of "tightened" disability regulations and procedures on the disabled.

Exhibit No. 1 is a copy of an internal SSA memorandum that deals with the cessation and denials of persons with mental impairments. The memorandum reflects the internal dispute over the application and interpretation and valididty of the disability regulations.

It contains several attachments including commentary from Psychiatric News (a publication of the American Psychiatric Association), a memorandum of the Wisconsin state agency, and an informal memorandum of a Chicago regional medical adviser for SSA.

Taken as a whole these documents illustrate:

SSA is utilizing quality assurance procedures and informal instructions (e.g. "Informational Digests") to narrow the allowability of claims; in effect, they are modifying the published regulations by stringent and untested interpretations.

Professionals, both in and out of SSA, doubt the validity of the disability regulations and procedures as they are being applied.

The particular practices described are adversely affecting the mentally ill, mentally retarded and developmentally disabled.

The memorandum of the Wisconsin state agency also reinforces the inclination of state agencies to disallow claims because of the pressure put on them by SSA.

Exhibit No. 2 pertains to the case file of "Karen", a 31 year old woman with so-called "borderline intelligence" who had been entitled to Social Security benefits since 1968 until her benefits were cut off in January this year. Included are copies of the CDI termination decision and copies of the medical evidence upon which it is based.

Note: This case was one of the so-called "profile CDI" cases in which SSA purported to examine high error-prone disabilities. Among profile cases are those with mental impairments.

Exhibit No. 3 pertains to the case file of "Charles", a young black male diagnosed with chronic schizophrenia. Included is a notice of termination of benefits, dated 1/4/81, and medical reports from 5/81 and 11/81 reflecting recent periods of hospitalization.

[Attachments]

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
SOCIAL SECURITY ADMINISTRATION,
January 25, 1982.

To: Office of Operational Policy and Procedures.
From: Office of the Regional Commissioner.
Subject: Evaluation of Residual Functional Capacity (RFC) in Psychiatric impairments—information.

The evaluation of psychiatric impairments which fall short of the listings is a continued problem in this region and, apparently, nationally. In our May 27, 1981 memorandum, we inquired about the instructions pertaining to the evaluation of RFC in mental impairments. Our concern was that while Informational Digest Item Part Two, C4.02A indicates that the younger worker with a severe mental impairment which falls short of the listings will generally retain the RFC for at least unskilled work, communications and returns indicated that in practice these are no exceptions in cases involving younger workers. Your response of August 3, 1981, similarly reinforces our observations in that the sole example of an exception pertained to a worker approaching retirement age.

Subsequent to our last communication, thousands of profile CDI's are being and have been processed by our DDS'. These include large numbers of claims with psychiatric impairments which do not meet the medical listings. We have advised our DDS' to approach the evaluation of RFC in these cases in the manner consistent with the communication and feedback to date. As a result, large numbers of cessations are being made and widespread public reactions have surfaced.

Your August 3 memorandum advised that action was being taken to clarify or replace Informational Digest, Part Two, No. C4.02A, and that you are attempting to develop RFC examples for mental impairments. We strongly urge that these activities be completed as quickly as possible in order to clarify this subject.

In order to provide you with background on the reactions to this subject we have enclosed a letter from the Wisconsin DDS (Attachment 1) which provides first hand reactions from the DDS management and staff. Other DDS' in the region have likewise expressed concerns about the large numbers of severely impaired claimants who are younger workers with mental impairments and who are currently being denied or benefits are being ceased.

The medical community, treating and consulting psychiatrists and community mental health centers, have expressed concern about the cessation of benefits for patients whom they consider to be severely impaired and incapable of resuming work activity. This reaction by the various components of our mental health system if frequently similar to the viewpoint recently expressed in a letter published in the November 20, 1981, edition of the Psychiatric News, a publication of the American Psychiatric Association (Attachment 2).

One Area Director, Field Operations, has provided feedback regarding field office employee reaction to some of the medical cessations involving beneficiaries with psychiatric impairments. He indicated that in some instances, the field offices are concerned that individuals whom they consider to be "obviously" disabled, based upon observed bizarre and unusual behavior and interviews at the SSA District Offices, are denied. The DO network has suggested a study whereby they observe and interview individuals who have mental impairments and are about to be medically ceased. While we have reservations about the study proposed, we do appreciate the concerns expressed by the DO and acknowledge that they are more than isolated reactions. The voluntary assumption of added work duties by the DO or Area Director is not ordinarily offered without due consideration.

We have encountered serious reactions from beneficiaries themselves. There have been several suicides in this region following Title II cessations and there have been other suicide threats and attempts, and threats to DDS employees and CE physicians from beneficiaries with mental impairments.

There has been reaction by the press and the general public regarding disability claimants and beneficiaries with mental impairments. The New York recently published an article regarding the growing number of homeless people in New York City (Attachment 3). While the article clearly indicates that there are other reasons for "street people" then mental illness, it nonetheless is of interest to us from one standpoint. The article contains brief profiles of several individuals, one who is reportedly on SSI. This profile of "Molly" is interesting in that we believe the general public would not question that she is "disabled," yet our Regional Medical Advisor's comments on this profile illustrate a contrasting viewpoint (Attachment 4).

In providing this background, we are not suggesting that the majority of disability denials and cessations on mental impairment claims are not appropriate. However, we believe that in a very small percentage of these claims, the case adjudication guidelines are applied too stringently.

Our Regional Medical Advisor has provided an analysis of the problem and has suggested some changes in the instructions for case-by-case application (Attachment 5). Briefly, he suggests a change in format and instructions for the psychiatric review form to provide for more equitable rating of the severity of certain mental impairments. Additionally, be cautions that assessment of the RFC involves more than translating the functional limitations to work-related capabilities. He suggests that the claimant's stress tolerance is also a critical factor in the RFC assessment. We believe this latter factor should be considered in POMS 238.1C.

In summary, we look forward to the forthcoming instructional changes identified in your August 3, 1981 correspondence and hope you will consider the additional suggestions and comments that we are at this time providing. The overall number of mental impairment claims is increasing with the addition of the periodic reexam cases and we believe that the problems we have identified should be timely resolved.

If you have any additional questions regarding this correspondence, please contact Bonnie Becker of Programs—Disability Programs Branch at (FTS) 353-3312.

Marlene M. Moleski,
Acting Regional Commissioner.

State of Wisconsin, Department of Health and Social Services, Division of Economic Assistance, Bureau of Social Security Disability Insurance,

Madison, Wis., December 29, 1981.

Re Adjudication of mental impairments.

Ms. Ollie Washington,
Assistant Regional Commissioner
Chicago, Ill.

Attention: Tom Curin.

Dear Tom: An SSA disability beneficiary commits suicide in front of a District Office in Michigan. A beneficiary threatens an adjudicator and then is found wondering in the DDS office in Ohio. These are but two of many instances, both reported and unreported, which suggest the gravity of the problem with which we are dealing and the level of feelings in the community regarding what we are doing. Some of it is inevitable with the CDI review. However, much of the feedback which we have begun receiving from the community on what was happening with mental impairments started well before we ever adjudicated an accelerated CDI. Since last spring, I have been hearing from mental health professionals that they have noticed we were allowing far fewer claims and we were terminating more of them.

The attached material expands on and illustrates some of the reasons for my concerns. A brief summary of these concerns and recommendations to deal with them follows:

(1) Trend reporting from DAB in terms of what they are seeing in their reviews is either very poor or non-existent and it's reporting which we need.

(2) Case returns in mental body systems which have cited the most minimal daily activities, with these activities possibly not even corroborated except by statements of the individuals who themselves are mentally ill, heavily influence disability adjudicators in their future decision making. This happens whether or not the case returns are meant to state or direct the application of new evaluation policies.

(3) The current adjudicative climate involving mental impairments seems to be one of deny, deny, deny. The rationales for these denials as promulgated by DAB reviewers, seem to be based on the most minimal possible understanding of mental impairments in terms of their effect on individuals, on the fluctuations involved in the behavior of those with such impairments and in trying to relate minimal ability to function in activities literally necessary to continued life, with the capability of going out in the competitive world and obtaining and holding a job with the normal stresses, under supervision and with the necessity to be able to perform consistently.

(4) The mental health community, including but not limited to local government bodies and advocacy groups, clearly is aware of what is going on. Their responses are going to get increasingly louder and they are relatively accurate in what they are saying at this time. While I continue to not believe that there is any specific intent to deny or terminate mentally ill applicants as opposed to the whole universe of applicants, I find it is impossible to come to any conclusion except that the impact of a much more stringent review of claims is falling very heavily on mental body system impairment applicants. As an individual with 17 years of experience in the Disability Program, including a significant period of time adjudicating claims or supervising adjudicators, my own reaction to the application of the current review criteria is that in many instances it is ludicrous and indefensible.

The recommendations which I would make are essentially summaries of what has been suggested by the staff feedback, some of which I have quoted in the enclosure. It includes:

(1) A clear-cut and I might add reasonable definition of the weight to be given to daily activities as opposed to mental status findings. This involves specifying how much one must or should look at the quality of daily activities rather than simply at their quantity.

(2) The current dichotomy in administration of DAB as opposed to the Disability Program Branch is an organizational problem which has got to be remedied. It is not going to be resolved by friendly exchanges in which excuses may be made by all concerned. SSA needs to think seriously about consolidating these functions once again.

(3) Almost immediately, it will be necessary to get a policy statement from a level sufficiently high to control both DAB and the Disability Program Branch, as to the need for a more responsible approach to the evaluation of mental impairments.

(4) Finally, we had better start preparing ourselves to respond to the concerns of the advocacy groups. Perhaps Central Office is prepared, especially after the most recent suicide, but I don't think any of us in the field are really prepared. At this

point, I would think that without a good deal more information, policy instruction and understanding of what is really supposed to be going on, we're quite likely to be providing all kinds of disparate information and most of it is not going to make us look any better.

Sincerely,

BOB COHEN, *Bureau Director.*

Attachment.

The comments in this material refer in part to the previous correspondence we've had about the area of pre-effectuation review of mental impairments, but it goes beyond that. The letters to which I am referring are my letter of June 17 coded M-RG #6517 and your October 8 response. Before diving into the meat of this communication, I would like you to know that the comments received by those people on my staff who reviewed your October 8 response were favorable in terms of the thoroughness of the response. Everyone was quite impressed with the amount of work which was done on the communication and the research which went into it. Several people commented that it certainly was encouraging to see our comments taken seriously and to see the degree of concern for the issues we raised reflected in the thoughtfulness of the response.

I shared the response with Jackie Rader and the Operations supervisory staff. I am going to quote from some of the individual responses but I would like to say first that the people did really say what was on their minds and they feel that the area of mental body systems review and decision making is a serious problem. I think it's safe to say that despite all statements to the contrary about DAB returns not setting policy, the fact is that DAB returns have very effectively set policy in this area simply by dint of the fact that one only has to get so many case returns reciting the same material before one changes one's method of decision making. Along those lines, we certainly wish that DAB had notified DPB that they were seeing a particular trend which was resulting in many more mental body system returns earlier last summer. Notification of trends is generally considered to be a QA function and we might have avoided some of the problems with large numbers of returns had we known what was going on.

Another observation which I want to make is that we heard at the recent QA Conference that there would be some guides coming out on daily activities. As you will observe from the material which follows, these guides are very much needed and I believe until we have them, there is going to be considerable disorganization with our thinking on how to adjudicate claims under the mental body system.

Increasing complaints led to the recent training session which we put on in conjunction with the State Division of Health where better than 60 mental health professionals and other concerned citizens met to listen to what we had to say about the adjudication of mental impairments. At the very same time that members of my staff were explaining development and documentation criteria, and assuring these individuals that individuals with mental impairments were not being singled out for denial or cessation, your October 8 letter to me was being circulated throughout my supervisory staff and was drawing remarks like the following:

"It was quite a surprise to see how Wisconsin had done compared to other states in the 3/81 and 6/81 quarters in reference to PER mental returns. I have noticed a marked decrease in PER mental returns in the past few months. As a matter of fact, I haven't seen any since 7/81.

The catch is that the adjudicators are allowing very few psychiatric cases. Quite frankly, a claimant has to be in a catatonic stupor or be a totally raving psychotic to be allowed. Claimants who are hallucinating, delusional, unable to relate to others . . . are being denied because they buy their own groceries or some such thing. . . ."

"I sure wouldn't want to supervise someone who heard voices and thought the government is trying to poison him/her but these claimants are being denied because they watch TV or do some minor activity. This is what DAB has indicated they want and these decisions are clearing their review."

"The examiners are very uncomfortable with the current policy for adjudication of mental cases. I agree with (the above) observations—DAB puts too much emphasis on minor activities of daily living as an indicator of capacity for work. Some of the daily activities of these people would be classified as survival activities. I see no relation between that and work capabilities. For those in 'the front lines' who must deny these unfortunate claimants, the whole situation is ridiculous—a bureaucratic merry-go-round. I hope that someone in Central Office can offer a realistic guide. If the rules are set up so that everyone gets denied, one starts to wonder why the Program even exists, outside of supporting government employees."

"As for the statistics, I think they can be manufactured to suit any need. If they are all based on the kind of returns DAB sends out, then I have no faith in them—their idea of quality is different than mine. We haven't had many returns lately, but I'm sure that is because we've been denying everyone that can still breathe and eat by themselves." (The individual who provided those comments also provided me with samples of several case returns, one of which was still in limbo as of the time this feedback was provided in November. The case situation indicates that DAB bounced it based on their evaluation of medical reports in file from 1980, whereas the claim was current and there was current medical evidence in file from July and August 1981 and the onset was in May 1981.)

Another supervisory comment was along the lines that it is apparent that we are changing our concept of disability from simply being objective and accepting conclusive statements about clinical findings, towards more emphasis on and further evaluation of functional restrictions. This individual felt that the Wisconsin DDS had actually been a forerunner in identifying the importance of function and I agree with that statement, since I have stressed function all along in my internal QA arbitration decisions. The fact that there is a perception that function has been stressed more in this Agency, and the reaction to the current trends in adjudicating mental disability claims is still so severe, probably speaks even louder for how far in what we consider to be an unreasonable direction the pendulum has swung. This individual goes on to say "The * * * [page of copy not supplied].

* * * * * * *

"Many claimants claim to do nothing during the day except watch TV. There seems to be a lot of room for difference of opinion as to how active a person must be before the listing is not met."

"I shudder when I see an allowance on a mental case nowadays, especially if the person has any activity at all, even if it is as simple as making meals."

"We could really use some guidelines on this. It appears that the DAB psychiatrists are taking a strict approach. Are they representing SSA policy? Or, could they be stricter than other reviewing MD's? We hate to adjudicate all our cases based on a few returns, but then again we don't want to get a lot of returns either!"

I didn't really want to expand the size of this communication but I felt it was important that you get a feel for what the people who are most closely connected with the disability claims outside of the adjudicators themselves, have to say. I don't think the supervisors who commented are just representing their own feelings because they're immersed in the feelings of their staff and to a considerable extent they are reflecting them. Thus, I think what we are hearing very clearly is that the staff has very little confidence in the way claims are being reviewed, in the criteria which is being utilized for adjudication of mental impairments. There is also a great deal of confusion about how far this is going to go and what we can or should be doing about it.

I looked at the statistical tables provided in your October 8 letter and indeed, to the extent that you cite them in your conclusions about PER review, they are quite accurate. However, there is a very large trend which those statistics clearly show but which you did not mention. That is, that in any head to head comparison between returns on allowance cases and returns on denials, allowance cases are being returned with a much heavier percentage than denials. Now let's don't get confused about this; I realize that PER is reviewing many more allowances. However, on a percentage basis, a review of allowances and a review of denials, even if the rate of review of denials is much less, should still yield relatively similar return rates within each review segment. It does not appear to be the case. Rather, allowances are being returned at a much higher rate than denials. This is true not only of PER but it is true of post-adjudicative review. Some months ago I had an opportunity to look at a set of statistics involving case return rates for each Region and the States within each Region, based on the post-adjudicative review. The very same thing was evident. That is, despite the fact that many more denials than allowances are being processed and therefore being reviewed at the post-adjudicative levels, the percentage rate of case returns is much higher for allowance cases than it is for denials. Thus, there seems to be an extreme pre-occupation with an unduly disproportionment return of allowances as opposed to denials. That policy on post-adjudicative review has clearly flooded over into pre-adjudicative review as well. It is impossible for this kind of review not to de facto set policy involving the heavy emphasis on denying claims to avoid case returns. In mental case review, since admittedly some of the criteria are more subjective, it becomes a much greater hazard to allow a claim because the range for difference of opinion between adjudicator and reviewer is great. This would seem to be entirely inappropriate since the judgment of the adjudicator should be supported unless the reviewer can clearly demonstrate that errors have been made. As all of the individuals who commented upon review of your letter said, there is and has been an absolute difference of opinion over what constitutes sufficient evidence of ability to function to deny versus to allow.

Finally, as you may be aware in any case, I think it's necessary to point out that there is and there is going to be a continuous escalation of the degree of resistance to what's happening in the mental body system area because of the attention this area has now received from public interest group quite apart from DDS's. As I mentioned at the beginning of this letter, this DDS discussed case documentation with a large group of individuals active in the mental health community about a month ago. Since then, I had the opportunity to review a newsletter of the Association for the Mentally Ill and several individuals from that organization visited our DDS and discussed the evaluation and documentation of mental disability claims with Jackie Rader and Wayne Lembke. What they said in their newsletter about what they were told at the interview was accurate but the newsletter clearly shows a belief on their part that the mentally impaired are being singled out and clearly indicates that they are dissatisfied with what is happening and they intend to do something about it.

More recently, I received a copy of an alert bulletin from the "Mental Health Law Project", which is apparently an organization in Washington, D.C. The subject of this alert was "Two Ways Mentally Disabled People are Losing Essential Services; One New Strategy to Protect Their Rights". It goes on to list the following areas:

Unjustified termination of disability benefits.

Discriminatory exclusion from Section 202 Housing.

New funding for community services.

This bulletin goes on to discuss the so-called unjustified termination of disability benefits. It says things like "Although review of the status of SSI and Social Security recipients is technically legitimate under the law, such reviews should not serve as a device to slash disability spending at the expense of those who are unable to support themselves. Severe mental illness, although disabling, is not easily measurable by objective medical tests. Furthermore, the patient's condition often fluctuates from week to week or month to month. Chronically mentally ill persons are therefore especially vulnerable to being summarily cut off from disability benefits, and that is what seems to be happening."

This bulletin goes on to indicate that since there are a large number of both government (state and local) and advocacy groups who oppose unjustified termination of disability benefits, this issue "might generate a particularly effective coalition. An essential element for such a coalition's success will be attracting public attention to the plight of chronically mentally ill people who have lost disability benefits." "We are particularly anxious for specific facts in individual cases."

Psychiatric Ne
November 20, 19
Attachment No.

Letters

[illegible]

Disability Exams

AT THE REQUEST of the Social Security Administration and other funding agencies, so that they can determine employability and terminate benefits, psychiatrists have examined chronic patients under psychiatric care in our day treatment program. According to the patients, they were seen very briefly, less than twenty minutes. How could anyone possibly determine so quickly whether or not a chronic psychiatric patient can be gainfully employed? Perhaps it is psychiatrists' ridiculous response to a ridiculous request on the part of these agencies. But, as is so often the case, the patient is the victim because the anxiety engendered by the resultant decision to terminate benefits and then the procedure to appeal the decision causes deep suffering and, for some, decompensation into an acute psychotic state.

By keeping our functionally handicapped patients in a low stress situation, we have been able to stabilize them, resulting in fewer rehospitalizations and an improved quality of life. Some do progress to involvement in sheltered workshops, further education and training, or even periods of employment. This process must be very gradual, with constant support and encouragement.

The consultant is then asked at some point along the way to see such a patient who is stable because of careful monitoring of stress, but not employable because of the inability to tolerate the level of stress he would encounter in the employment market.

I think such a psychiatrist is doing a disservice to our profession to act (under these conditions) as a consultant to funding agencies, thus perpetuating a monitoring system that has no validity for chronic psychiatric patients. To be valid, such consultation would require extensive perusal of background material, discussion with the treating psychiatrist, and at least several sessions with the patient and significant others.

Since this level of involvement is neither practical nor compensated, should we not all refuse to accept such consultations, thus forcing the system to find a better way to ascertain readiness for termination of bene-

~~tool to further their own private political interests: I wonder whether the Board has learned from the lessons of last year that the majority of the members of APA want APA to spend its money, time, and influence on professional issues and improved care of psychiatric patients. They do not want the Board to waste its time as it did last year in long arguments about social and political issues that have no relevance to our profession or to our patients.~~

~~This proposed symposium on the "Medical Aspects of Nuclear War" is nothing more than the efforts of some pacifists (and others) to start a grassroots movement to reduce American defense preparedness. It is against the national interests of our country and an interference into our foreign policy and relationship with NATO countries. I am sure that our sponsorship of this symposium would have a very negative influence on the present administration in Washington and would hamper greatly our ability to influence the administration to support us in our~~

See "Letters," page 18

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Attachment No.

OFFICE OF DISABILITY OPERATIONS **MEDICAL CONSULTANT'S CASE ANALYSIS**	REFERRING OFFICE
	A/M
	NAME "Molly"
	STATE
	DATE

For purposes of illustration relative to the difference between our program's view and that of the society at large concerning these patients, we are providing some comments on a particular case ("Molly") of a chronic mentally ill individual as described in a recent issue of the New York Magazine.

Although Molly's case is not fully documented by any means, her daily activities have been described to sufficient detail to indicate:

1) She is able to take public transportation.

2) She has good enough reality contact to search five or six differen buildings for clothes.

3) Her personal appearance and grooming is intact.

4) The initial impression she makes is not bizarre (carries one pocketbo only).

5) She has a routine to her daily living (ends her wanderings at 6 a. every morning).

6) She is able to produce drawings that look as if they were rendered b commercial artist.

7) Evidently, during the interview, her speech, presentation of thought, general demeanor did not indicate any dramatic abnormalities.

It is reasonable to conclude that this patient will fall short of our listi based upon her described daily activities. The information is insufficient rate her impairment in detail on the psychiatric review form. However, it be stated that her symptoms do not fall under effective intelligence affective status. Thus, under reality contact she would have to sco rating of 5 in order to be an allowance. Based upon her daily activit this rating is unlikely.

Nevertheless, the public relations ramifications of the denials/cessatio these individuals is obvious to all of us.

Sandor Berendi, M.D
Regional Medical Adv

SBerendi:dab

Attachment N

Medical Consultant Comments

The Problem: Currently, a significant number of psychiatric patients who clinically manifest an inability to engage in persistent substantial gainful activity are denied disability benefits due to the fact that they fall short of the psychiatric listings. Many individuals with serious residual symptoms (mostly chronic schizophrenics) have made a marginal adjustment to everyday demands of semi-independent living outside of a mental institution, only while they are not under any psychological stress. Usually they also require various supporting services (e.g., local Community Mental Health Centers, Social Workers, and RN's in half-way houses, etc.). The overwhelming majority of these individuals are currently denied as having a severe impairment with an RFC enabling them to do at least unskilled work. The problem arose when Informational Digest #79-32 was issued indicating that ..."The younger worker whose mental impairment severity falls short of the listings would "generally" have a favorable vocational adjustment..." Subsequent discussions with CO/MCS as well as case reviews from CO reviews indicate that virtually all younger workers in this category are found capable of SGA.

Prior to the issuance of this Informational Digest item, most of these claimants were allowed on a medical-vocational basis with an impairment severity rating of "severe with functional restrictions" and a residual functional capacity unfavorable for any kind of work.

The Impact: Large numbers of schizophrenics who have been receiving disability benefits for years are ceased on CDI. Only a negligible number of new applicants are allowed, as it is practically impossible to meet Listing 12.04 for any individual whose thought processes are not completely disorganized, is not blatantly psychotic, or is not having a psychiatric emergency requiring immediate hospitalization. In fact, an individual may be commitable due to mental illness according to the States' Mental Health Codes and yet found capable of "unskilled work" utilizing our disability standards.

Many components of our mental health system are outraged by the denial of patients who they consider very sick clients. The claimants themselves are usually the least vocal about their situation, partially due to their inability to comprehend the impact of the disability decision on their life, partially due to lack of social skills inherent to their mental condition.

Practicing psychiatrists complain that indigent patients are deprived o quality care, as destitute patients only on disability (not Genera Assistance) are paid for private psychiatric services.

Psychiatrists and social workers in community mental health centers regard th government as unreasonable and lacking in compassion when their patients w had 10-15 hospitalizations for psychiatric episodes are told that they c work while in their outpatient treatment plan; it is a "long term goal" teach them to do their own laundry. A psychiatrist recently called m outraged, promising to write to his Congressman about similar patients. (Th information was relayed to Herb Blumenfeld, M.D.) To indicate the sentime among some psychiatrists, we enclosed a copy of a letter published recently the Psychiatric News. That article is not inconsistent with the types of reactions we are receiving from a number of treating and consulting psychiatrists. During my visit to the Illinois DDS on November 12, 1981, that agency's Chief Medical Consultant advised me of similar sentiments among psychiatrists in Springfield.

DDS Administrators, during our regional meeting on November 10, 1981, unanimously voiced concerns about increasing security problems, suicidal threats from CDI beneficiaries, and complaints against consulting physicians who are inappropriately blamed by the public for the denials.

Reasons for the Problem: Two distinct administrative reasons can be identified which factors in combination resulted in our current situation:

1. The aforementioned item in the Informational Digest implies that the momentary level of functioning can be sustained and will not deteriorate with the added stresses relative to a work situation.

   For example, at present, an individual with auditory hallucinations which are "frequently present and disturbing" along with "frequent and disturbing" paranoid delusions associated with significant loosening of associations, along with significant withdrawal and seclusiveness, will be rated as a severe impairment with functional restrictions. The claimant, according to the aforementioned principle, retains the ability for unskilled work. The fact that this individual's momentary impairment severity is achieved by artifically low psychological pressure and anciliary support (outpatient facility,day care programs, social work outreach services, half-way houses, staff supervision, etc.) is completely omitted from the RFC. In the described example, the claimant would be expected to understand, remember and carry out instructions, respond appropriately to supervisors and co-workers and respond appropriately to customary work pressures in a routine work setting.

2. The second reason is the current method of utilizing the psychiatric review form for assessing the psychiatric impairment. Currently, the manual for the use of the psychiatric review form instructs that the overall degree of impairment severity of each "area" (effective intelligence, affective status and reality contact) be rated generally as high as the most impaired item within the area. An exceptional provision if given: in rare instances where 50 percent of all items within the area are rated the same severity (if the ratings are at least severe with functional restrictions equals 03), a rating of one degree higher can be granted. The total severity rating then is approved according to a specific formula:

   Any single area rating equals 05

   Total impairment rating equals 05

If none of the "area" ratings are 05, a special combination of the overall impairment rating of the three areas is computed.

In these latter cases, effective intelligence, as well as affective status and reality contact contribute respectively in the total psychiatric impairment severity rating. In the psychiatric review form the various items (symptoms) are grouped together in such fashion that claimants with residuals of a psychotic disorder are not properly weighted for serious psychiatric abnormalities. All customary residual symptoms of schizophrenia are grouped under that area of "reality contact".

As a result, barring additional mental retardation or a distinctly separate additional psychiatric impairment, an individual with the only abnormal finding of moderately severe degree of withdrawal will receive the same total impairment severity rating as all other claimants with the same degree of withdrawal, plus moderately severe degree of auditory hallucinations and moderately severe degree of paranoid delusions. These grave additional symptoms, which are "frequently present and disturbing", are not reflected anywhere in the total psychiatric impairment rating.

Proposed Solutions:

1. Change stipulations of the current instructional manual relative to the use of the psychiatric review form. If the severity rating of the various items within the same area would be combined according to the same formula as "overall" degree of impairment of separate areas are, claimants with multiple symptoms falling within the same area would receive a more accurate, precise and equitable rating.

2. Change the Psychiatric Review Form. One could regroup psychiatric symptoms in such fashion whereby not all residuals of a psychotic condition are under the same "area". This would enable schizophrenics with serious residual symptoms to receive a more equitable rating.

   Withdrawal/seclusiveness (Item #7) are under reality contact. One of the most frequent residual symptoms of schizophrenics, flat affect, is currently rated under this item. However, an affective change is currently rated under the "area" of reality contact instead of the more appropriate "area" of affective status. Thus, transferring item #7 to the "area" of affective status would more appropriately group the effect of the impairment and the residuals.

3. Expand the POMS section relating to evaluation of RFC in mental impairments to reflect the highly dynamic nature of this type of condition.

It should be considered that the complex psychological functioning necessary for sustained work activity cannot be translated as easily from non-work related functioning, as most physical conditions permit. The fact that increased psychological pressure results in regression of overall ego functioning and reality contact is a phenomenon almost invariably present in psychiatric impairments and rarely in physical conditions. Therefore, an added factor is required to extrapolate psychiatric RFC. This factor should reflect the claimant's stress tolerance as well as the current functioning.

Sandor Berendi, M.D.
Regional Medical Advisor
Chicago Regional Office

SBerendi:dab

☆ U.S. Government Printing Office 1981—341 191 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

CESSATION OR CONTINUANCE OF DISABILITY OR BLINDNESS DETERMINATION AND TRANSMITTAL

DESTINATION: DO ☐ PSC ☐ DAB ☐ ODO-CO ☒ DIO ☐

1. SOCIAL SECURITY NUMBER [redacted]

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing public law 93-233

2. A. NAME OF PAYEE *(IF ANY)* Ramsey County Welfare for

3. WE'S NAME *(IF CDB OR DWB CLAIM)*

B. NAME OF DISABLED OR BLIND INDIVIDUAL Karen [redacted]

4. DATE OF BIRTH 09/01/49

5. DATE DISAB BEGAN 04/10/68

C. ADDRESS
160 E Kellogg Blvd
St. Paul, MN 55101

6. DO ADDRESS
316 N Robert St Rm 185
St. Paul, MN 55101

7. DO AND DDS CODES 677 240

8. TITLE II - DIB ☒ FZ ☐ DWB ☐ CDB ☐ CRD ☐ TITLE XVI - DI ☐ DS ☐ DC ☐ BI ☐ BS ☐ BC ☐

9. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED THAT THE APPLICANT'S DISABILITY:
- A. ☒ CEASED 11/81 PD. OF DISAB TERM AT THE CLOSE OF THE LAST DAY OF 01/82
- B. ☐ IS CONTINUING
- C. ☐ IS BLINDNESS AS DEFINED IN SEC 216(i) AND
  - (1) ☐ WE NOT DISABLED FOR CASH BENE. PURPOSES SINCE
  - (2) ☐ BENE. TERM.
  - (3) ☐ WE UNDER DISAB. FOR CASH BENE. PURPOSES SINCE

10. UPON CONSIDERATION OF ALL FACTS, IT IS DETERMINED THAT
- A. ☐ DISAB. CEASED ______ STATE PLAN LAST MET ______
- B. ☐ ELIG. TERM. AT CLOSE OF LAST DAY OF ______
- C. ☐ DISAB. CONTINUES
  - (1) ☐ MEETS FEDERAL CRITERIA
  - (2) ☐ MEETS STATE CRITERIA
  - DA or A ☐ (DOES) ☐ (DOES NOT) CONTRIBUTE TO FINDING.
- D. ☐ BLINDNESS CEASED ______
  - (1) ☐ INDIV. NOT DISABLED/ELIG. TERM. AT THE CLOSE OF THE LAST DAY OF ______
  - (2) ☐ INDIV. DISABLED/ELIG. CONTINUES
- E. ☐ BLINDNESS CONTINUES

CL/ss

BASIS FOR DETERMINATION

11. DISABILITY/BLINDNESS CEASED ON SHOWN DATE BECAUSE
- A. ☒ IMPAIRMENT NO LONGER OF SUFFICIENT SEVERITY TO PREVENT SGA
- B. ☐ NO IMPAIRMENT FOUND BECAUSE OF FULL-TIME UNRESTRICTED WK
- C. ☐ ABILITY TO ENGAGE IN SGA DESPITE IMPAIRMENT - TWP COMP
- D. ☐ ABILITY TO ENGAGE IN SGA DESPITE IMPAIRMENT - NO TWP
- E. ☐ NO IMPAIRMENT - TWP COMP
- F. ☐ WHEREABOUTS UNKNOWN
- G. ☐ FAILURE TO COOPERATE
- H. ☐ OTHER *(EXPLAIN IN REMARKS)*

12. REASON FOR CONTINUANCE
- A. ☐ IMPAIRMENT DISABLING - NEW MED. EVID. NO WK. ACTIVITY
- B. ☐ IMPAIRMENT DISABLING - NEW MED. EVID. - WK NOT EVAL.
- C. ☐ WK. NOT SGA - IMPAIRMENT DISABLING - NEW MED. EVID.
- D. ☐ WK. NOT SGA - NO MED. ISSUE - NO NEW MED. EVID.
- E. ☐ STAT. BLINDNESS/TITLE II BENEFITS CEASE
- F. ☐ TITLE XVI BLINDNESS TERM./DISAB. BEGINS
- G. ☐ OTHER *(EXPLAIN IN REMARKS)*

13. ☒ CHECK IF SSA-834-U5 IS USED. *(USE SSA-834-U5 FOR EVIDENCE AND REASONING)*

14. WHY INVESTIGATION WAS MADE
- A. ☐ MED. RE-EXAM DIARY
- B. ☐ TWP DIARY MATURED
- C. ☐ EARNINGS POSTED - MED. RE-EXAM SET
- D. ☐ EARNINGS POSTED - NO MED. RE-EXAM
- E. ☐ VOL. REPT. OF RETURN TO WK - MED. RE-EXAM SET
- F. ☑ VOL. REPT. OF RETURN TO WK - NO MED. RE-EXAM
- G. ☐ VOL. REPT. OF MED. IMPROVEMENT
- H. ☐ STATE VR REPORT
- I. ☐ PFL REVIEW
- J. ☒ OTHER *(Specify in Remarks)*

15. OTHER ENT. ☐ TITLE II ☒ TITLE XVI

16. VR ACTION: SC. IN A. ☒ SC. OUT B. ☐ PREV. REF C. ☐ RE REF D. ☐

17. DIAGNOSIS borderline intelligence

18. DIARY DATE ☐ TWP ☐ MED ☒ NONE

19. ☐ RECON ☐ HEARING ☐ REOPENING

20. REMARKS

Profile CDI Case

21. DISABILITY EXAMINER	22. DATE 12/11/81	23. SECOND DISABILITY EXAMINER Rebecca Dougherty	24. DATE 12/11/81
25. REVIEWING PHYSICIAN [illegible] MD	26. DATE 12-11-81	27. SECOND REVIEWING PHYSICIAN William [illegible] MD	28. DATE 12-14-81
29. LTR. PAR. NO. S	30. LIST NO.	31. SSA REPRESENTATIVE	32. SSA COMPONENT / 33. DATE

34. FOR PSC-OBS USE

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Social Security Administration

CONTINUATION SHEET
FOR DISABILITY DETERMINATION

CONTINUATION OF RATIONALE OF SSA-831-U5 OR SSA-833-U5

NAME OF CLAIMANT	WE'S NAME (If CDB or DWB Claim)	SSN	TYPE OF CLAIM
Karen [redacted]		[redacted]	DIB

page 2

Louis L. Flynn, M.D. - report of neuro-psychiatric evaluation dated 11/17/81
Ardell W. Diessner, M.D. - report dated 11/19/81
John L. Richardson, Ph.D - report of psychological evaluation dated 11/16/81

The applicant was originally found disabled from 04/10/68 due to mental retardation with an IQ of 66 and a psychosis with epilepsy. This claim is now being re-evaluated under the provisions of the 1980 Social Security Amendments.

Medical records now show the applicant's intelligence is above the level that in itself is felt to constitute disability. There is no evidence of a physical or emotional problem at that presents additional restrictions. The claimant is able to interact well with other people. There is no current evidence of a major thought disorder. She presents an adequate personal appearance, and appears able to take care of her own needs. There are no indicatio that seizures currently are a problem..The severity of the individual's impairments do not meet or equal that of any impairment described in the Listing of Impairments. Based on the medical records previously referred to, the applicant is able to make independent and acceptable judgements. She can remember, understand and carry out instructions and procedur She can respond appropriately to work pressures and supervision. She is able to meet the basic demands of unskilled work.

The claimant was born on 09/01/49, based on the baptismal record dated 10/09/49. The claimant alleges on the SSA-401 dated 07/24/69, she has a 10th grade education, and psychological testing indicates she has borderline intelligence. No description of the claimant's work history is available, but the earnings record dated 08/13/69 shows the claimant's earnings were below the level that constitutes substantial gainful activity.

Considering the applicant's young age, borderline intelligence, lack of a relevant work history, and unrestricted physical abilities, the claimant is able to adapt to simple, unskilled jobs such as:
- bag stringer (paper goods ind) - DOT 794.887
- cutter helper (any ind) - DOT 781.887
- newspaper inserter (printing and publishing ind) - DOT 249.887

Minnesota County Business Patterns (1979) indicates there were 16,905 jobs in paper and allied products, 34,062 jobs in printing and publishing, and 1,448,513 jobs in the state economy, so an adequate pool of potential jobs exists. Disability is found to have ended as of Dr. Flynn and Dr. Richardson's examinations in 11/81, with benefits ending in 01/82.

S	12/11/81 CL/SS	LcT	12-14-81 (INITIAL AND DATE)				
DISABILITY EXAMINER DDS	DATE	REVIEW PHYSICIAN	DATE	DISABILITY EXAMINER SSA	DATE	DISABILITY EXAMINER SSA	DATE

Diagnostic Testing Services
JOHN L. RICHARDSON, L.C.P. & ASSOC.
1185 W. BROOKS \ ROSEVILLE, MINN. 55113 · BUS. 339-5527 484-9062

PSYCHOLOGICAL EVALUATION

TO: Conrad Leighton, Disability Examiner

RE: [redacted]
AGE: 32
DATE: 11/16/81

WECHSLER-BELLEVUE ______ W.A.I.S. x W.I.S.C. ______

Verbal Scale	Score	Performance Scale	Score
Information	4	P. Arrangement	6
Comprehension	6	P. Completion	6
Digit Span	7	Block Design	5
Arithmetic	4	Object Assembly	7
Similarities	8	Digit Symbol	4
Vocabulary	5	--	
Verbal I.Q.	74	Performance I.Q.	72
Full Scale I.Q.	71	E.Q.	

STANFORD BINET L.M. ______

GRAY READING TEST x JASTAK ______
Reading grade level - 4

CORNELL INDEX: (Read to the client)
Complaint score - 24, an extremely high complaint index, with the client appearing both phobic and schizoid in personality structuring.

PORTEUS MAZE TEST:
Age - 8½ years
Test quotient - 70

PERSONALITY MEASURES:
T.A.T. ______ MMPI ______

BENDER GESTALT TEST:
Testing time - 4 minutes, 15 seconds.
Quality of work - defective, of an approximate 7-year developmental phase.
Number of recall figures: 3

CLINICAL IMPRESSIONS:
Mild generalized retardation, long-term brain damage syndrome, complicated by epilepsy and rather severe emotional problems.

Karen [redacted]

PSYCHOLOGICAL EVALUATION - page 2

CLINICAL BACKGROUND: The client is a recent Diagnostic Testing Service referral from Conrad Leighton, Social Security Disability Examiner. The client was seen at my St. Paul Office accompanied by her mother and boyfriend on 11/16/81. The client is of tall, gaunt appearance, extremely shallow affect and talks in a most stereotyped, schizoid fashion. She earlier attended special classes at Mounds Park School, but apparently dropped out of school at age 16. She was also earlier hospitalized at Hastings, probably for a combination of problems eminating from her borderline intelligence and severe depressive characteristics including social withdrawal and occasional suicide attempts. The client is also described as subject to epileptic seizures, the fall down or pass out type, with these seizures still occurring at least monthly and appearing to be of the grand mal type. I believe the client was earlier married, then divorced, and now is apparently living with a boyfriend who also appears to be slightly schizoid in affect, but perhaps slightly brighter in an intellectual sense than the client. The client had some earlier experiences as a cafeteria worker, working at least briefly for the Red Cross in St. Paul and she was also assigned to a sheltered work station, at one time, at the St. Paul Rehabilitation Center. One child, resulting from her earlier marriage, a girl I believe, was adopted out since the client was not able to cope with motherhood and child rearing. Even now I view the client as in rather precarious state of general mental health, she apparently lives on a combination of Medical Assistance and Social Security Benefits and is making, what I would term, a marginal adjustment to community living, now attempting apartment life with her boyfriend and having earlier resided at the Hillman Board and Care Center in St. Paul under welfare sponsorship.

ABILITY APPRAISAL: On the W.A.I.S. the client scored within borderline limits with a full scale I.Q. of 71 recorded. She reads at an approximate fourth grade efficiency level as measured on the Gray paragraphs, though her reading comprehension skills are much more restricted. Her range of general academic information is quite narrow, she has only a very basic knowledge of math and she is extremely naive and exploitable in a social sense. Her reasoning is best accomplished in concrete terms rather than abstractly and her verbal memory function is quite limited. Although she is not severely retarded, her emotionality and schizoid personality characteristics tend to further complicate the educational and vocational prognosis here.

On performance tasks, the client was painstakingly slow in her finer visual-motor reactions and seemingly unaccustomed to clerical routine. Her sense of visual detail was scattered as was her social perception, foresight and planning ability as measured on cartoon sequences. She seemed even more restricted in regard to basic design and assembly tasks, usually subject to a rather serious degree of perceptual blocking and she appears to be irreversibly brain damaged. I would describe her current level of functioning as below sheltered workshop norms, more like that of a dependent, inadequate personality type and individuals who are more severely retarded and in need of work activity center programming. On supplementary testing through the use of the Porteus Maze, the client scored at a test age of eight and one-half years, with a resultant test quotient of 70, a score which closely approximates her measured I.Q. level on the W.A.I.S.

PERSONALITY APPRAISAL: The client's initial approach to testing was a bit timid and fearful and she is quite stereotyped in her verbal/social mannerisms and even her speech is clipped and high pitched. The client's Bender Gestalt drawings were recognizable though almost all figures were severely distorted perceptually and she had particular difficulty with angular figures. On recall she was able to reproduce three or her original nine figures which exemplifies rather borderline visual retention. Since there was, in my mind, a serious question as to the client's personality structurin the shallowness of her affect, and almost childlike schizoid behavioral mannerisms, I asked her mother and boyfriend to read through the Cornell Index with the client, a

Karen [redacted]

PSYCHOLOGICAL EVALUATION - page 3

complaint index listing 100 symptoms of general physical and psychosomatic problems. Here her resultant complaint score of 24 compares to that of 6 in normal adult populations The client pictures herself as subject to fainting spells, she is afraid of strange places and becomes extremely nervous and shaky when approached by a superior. She frequently gets directions wrong, she is confused in her thinking, and must work quite slowly in order to get things even minimumly correct. She also pictures herself as a constant worrier, she still has fear of having further mental breakdowns, and admittedly she has been frequently in need of psychiatric care. The client also states that she has recurring thoughts which appear to be of a compulsive nature, she is also troubled by facial twitching, and recurring grand mal seizures. She pictures her general physical health status as frail, she is easily fatigued, and sometimes troubled by attacks of nausea. In addition, the client is almost paranoid in regard to her social orientation, she feels that she is being watched at times, and she is highly irritable and emotional. Again the general clinical picture presented here is that of a phobic or schizoid personality type, an individual who is not only mildly retarded, but also still subject to an underlying seizure disorder and considerable confusion in her social adaptation and life style. She might even be described as a simple schizophrenic personality type though generally this psychiatric type is not as intellectually restricted as the client with her generalized retardation, again being more organically determined than irreversible in nature.

CLINICAL/VOCATIONAL RESUME: The client is a tall, gaunt, frail appearing 32 year old woman who tests within borderline defective limits on the W.A.I.S. She is a beginning reader though rather severely retarded academically. Her immediate verbal attention span is short, she is extremely simplistic in her social reasoning and could be easily exploited while at large in the community. She has no salable knowledge of math, she is extremely slow reacting on visual-motor tasks, and subject to a rather severe degree of perceptual blocking. The client is multiply handicapped in that she is mildly retarded irreversibly brain damaged, and also subject to an underlying seizure disorder, as well as schizoid personality characteristics. She has a long history of social and emotional maladjustment, she has been hospitalized, in the past, at Hastings and her earlier brief attempts at rehabilitation, both at the St. Paul Rehab Center as a sheltered worker and at the local Red Cross Office as a cafeteria worker, resulted in failure. At this point in case planning I would not term the client an even likely candidate for sheltered workshop activities though she might benefit in a social/recreational sense from some degree of work activity center program. In the event she continues to receive welfare and Social Security Benefits, based on my present test results and clinical impressions, I would suggest that these funds be closely monitored by a legally appointed guardian figure since the client is really not capable of financial self-management. I am even rather questioning in regard to her present living arrangements, she is apparently attempting apartment life with a boyfriend who probably has his own set of problems and in the event this arrangement does not work out, the client might be more comfortably placed in a more structured boarding house environment or in a residential center designed to deal with individuals who are of borderline intelligence with complicating emotional problems.

John L. Richardson

John L. Richardson
Licensed Consulting Psychologist

JLR/ya

[redacted] [redacted]

SSN

Examiner
Conrad Leighton

Disability Determination Services
Metro Square, Suite 460
7th & Robert Streets
St. Paul, MN 55101

This transcription was made from the voice of:

Doctor Louis L. Flynn, M.D.

Address

Thank you for using our telephone dictation service. Plea make any necessary corrections, sign and return the yell copy in the enclosed envelope. An extra copy is included i your file. This report will be included as evidence in the d ability claim of the above captioned claimant.

NOV 18 1981

On the 16th of November, 1981, I examined your client, Karen [redacted] at your request. Prior to my examination I had available to me a medical discharge summary from Hastings State Hospital which was typed on 13th of November, 1969. There was also a medical report from Mounds Park Hospital in which Karen's hospitalization at Mounds Park Hospital was summarized. This report was dated 10-16-69 and is part of your file. Karen [redacted] appeared for her appointment on time. She was accompanied by several relatives who waited in the waiting room for her. The history I obtained is as follows.

HISTORY: Karen was born on the 1st of September, 1949 in St. Paul, Minnesota. Her father died in 1976 at the age of 52 of cancer. He was a machine operator and had a good employment record. The patient's mother is 54 years of age and she is a housewife. The patient says about her mother "she is on disability for something, I don't know what. She was in the hospital for her nerves at Ramsey Hospital." The patient does not know if her mother receives disability compensations. The patient has two brothers, 25 and 34 years of age. The 25 year old brother is not working, although he has had a part-time job driving a truck. The patient's older brother is a janitor and is steadily employed. The patient has no sisters. The patient is of the Protestant religion and says that she sometimes attends church. The patient says "I quit school in the 9th grade and I went to Hammond School because the kids in the other school made fun of me". The patient says that she was made fun of because she was unable to read. The patient then went on to say that she quit school at the age of 16 and she says that she worked at the Red Cross washing test tubes for about two months. The patient says that since that time has lost that job because "my boss quit and I got fired". The patient married [redacted] and she says of this marriage "I don't know what year I married him. I was 23 years old." "I was married for four years, my husband divorced me because I had a nervous breakdown." Apparently the patient was married in 1972. Her husband is now about 33 years of age and in discussing her husband the patient says "he worked by the river but I don't know the name of the place. I can't remember what kind of work he did, but he came home all dirty." The patient had one child in 1974, a girl. This child was adopted out because the patient felt she was unable to take care of her. The patient says"she would be 5 or 6 years old now, but I don't know what year she was born in".

MEDICAL HISTORY: The patient was asked about what medical problems she has had and she gave the following history. "My tubes were tied after I had the baby because the doctor said if I had another baby I would have a nervous breakdown, a doctor at Ramsey Hospital told me that. I had a nervous breakdown when I was 18 years old and I was hospitalized five or six times for nervous breakdowns since that time." The patient says that she did have ECT on at least two occasions. The patient went on saying "I went to Hastings State Hospital and I later went to Rochester State Hospital and stayed about two or three months. Next, I went to Anoka State Hospital. When I got out of Anoka State Hospital I lived at a board and care home. The last one was the Hillman's and I did very well there. I moved out of the Hillman's Home on the 30th of October, 1981 and into an apartment with my boyfriend. I don't know if I'll get married. I met him at Mounds Park Hospital and I have known him for about three years." The patient says that her boyfriend is about 26 years of age and was never married before and she says that her family knows him and likes him. This boyfriend has no job and he is on welfare because "he has back trouble". The patient says that she had seizures for the past two years. She says "I'm now on the right medicine and I haven't had a seizure for about 1½ years." The patient has no seizures now, but she says "I feel weak and shaky sometimes and I wonder if that's a seizure". The patient's current medications are: Dilantin 100 mg four times a day, Mellaril 200 mg at bedtime and 25 mg twice a day. Trilafon 50 mg four times a day. The patient says that her medicines are supervised by a Doctor Diessner who is a psychiatrist whom she sees about once a month.

SOCIAL HISTORY: The patient has been in special classes all of her life for slow learners or for retarded people until she quit school at the age of 16. The patient has been on social security since the age of 18 because of her frequent hospitalizations around that time for mental illness. The patient is unable to drive a car and has never learned. The patient says that she can cook some, but not particularly well. She says that her social life consists of movies, watching TV and radio. The patient says "I don't know how to read, I read the paper a little, but not much. I go for walks and play tennis with my boyfriend." The patient belongs to no clubs or social groups of any kind. However, she does go to a county founded club called the Apollo Club and she says she and her boyfriend play games there and meet other people. She says "we see my mother and my brothers on holidays, like Thanksgiving and Christmas." The patient has never been on a trip alone, but she told of going to Duluth with her father. She said "I don't know the way and my boyfriend doesn't drive so we can't get there I guess." The patient says "I don't have a medical doctor. I think I'd ask my mother if I needed a doctor." The patient says that she has one girlfriend and she says "we get along well and my brother is now going with her".

MENTAL STATUS: A great deal of the mental status is contained in the above history through the quotation marks and other commentaries. However, the patient was cooperative and seemed to comprehend the purpose of this examination quite well. She was very simple, direct and apparently straight forward in her answers. She did not dramatize her illness or her disability, in fact, she behaved as though she considers her health to be quite well at the present time. There is no attempt to dissemble or to dramatize her symptoms. The patient did not know the names of any of the major politicians in the state, neither the governor, mayor, or senators, but she did know the president of the United States. The patient says "my social worker sends me my money on the 10th and the 25th of each month". The patient says that she does not like her social worker particularly well and she is going to try to ask for a different social worker. There is nothing bizarre in the patient's behavior or in her ideation. She was quiet and soft spoken.

When she was asked simple questions requiring the ability to add or subtract, she did extremely poorly . The patient was asked to name five of the larger cities in the United States and in her list she named three states and didn't seem to know the difference. A psychological test is being done by a psychologist as a part of this total work-up.

NEUROLOGICAL EXAMINATION: It was noted that the patient has a skin mark on her upper right arm extending to her shoulder which looks like a faint cafe au lait birth mark. This is irregular and spotty and I could not say that it is absolutely typical of other cafe au lait spots. If the patient had not pointed it out, I may have missed it in my examination. The patient's gait is normal, although she is mildly awkward in all of her motions. She is able to walk well on heel or toes and to do tandem walking. There is no evidence of paralysis or paresis, nor are there any lateralizing signs. Rapid coordinated movements were done well. Again they were done awkwardly. The patient had a negative Romberg sign and negative Babinski sign. The reflexes were equal and normal throughout the body, both deep and superficial reflexes. Sensation was normal over the entire body in all modalities. The cranial nerves were essentially negative. Impression: Negative neurologic examination.

ASSESSMENT: In summary, we have a patient who has a several year history of mental illness with acute psychotic breakdowns. This is well confirmed and apparently her treating psychiatrist at this time believes that she has to be maintained on tranquilizing drugs. The patient also has a history of seizures and again her treating doctor believes that the patient requires Dilantin to help her to control seizures. The patient is extremely simple, naive and apparently is retarded, but probably in the educable range of retardation. She is obviously a very dependent person and I doubt that she can manage her own money. I doubt that this person would be able to work in anything but the most unskilled of labor and in a highly supervised setting, probably a sheltered workshop. The patient is reasonably neat and clean and cooperative. There is no evidence of anxiety or regressive behavior at this time and she is not depressed, nor is she insomnic, anorexic, or have any obvious signs of neurotic anxiety or of psychosis.

Please feel free to call me if you have further questions.

Louis L. Flynn, M.D.
LLF:MTS:nf

Social Security Notice

From: Department of Health and Human Services
Social Security Administration

Date: NOV 04 1981

Claim Number: [redacted]

Ramsey County Human Services for
Charles [redacted]
[redacted]

Dear [redacted]

This notice concerns your continuing entitlement to benefits under the Social Security Disability program.

The law provides that an individual's disability period shall end if the person is able to do substantial gainful work. The law also provides that an individual will receive benefit payments for the month disability ends and the following two months. The medical evidence in your case shows that you became able to do substantial gainful work in 10-81. Accordingly, the last disability benefit to which you are entitled is for the month of 12-81.

You were originally found disabled due to an emotional disorder and seizures. You said you still have seizures and have been hearing voices for about 2 1/2 years. Your seizure disorder is under fairly good control with your last seizure occurring 4 or 5 months ago. You are able to interact well with other people. You have several activities and interests. There are signs you do hear voices but they do not severely effect your ability to function. You are able to tak care of your own needs. Although you have never worked very long, we conclude you now are able to do simple unskilled jobs.

If your condition again prevents you from doing substantial gainful work before age 62, you should get in touch with any social security office about filing a new application for disability benefits. If you apply promptly and are again found entitled to disability benefits, your benefit payments may start with the first full month in which you are again disabled.

The decision on your claim was made by the Social Security Administration on the basis of a disability determination by an agency of the State in which you live. Physicians and other trained disability evaluation personnel in the State agency participated in making this determination.

This decision refers only to your claim for benefits under the Social Security Disability Insurance Program. If you have not already received a decision about your payments under the Supplemental Security Income Law, you will receive it shortly by a separate notice.

Form SSA-L951 (5-80)

You believe the decision shown on the other side of this notice is wrong, or

You have any questions or need more information.

Most questions can be handled by phoning or writing any social security office. If you visit a social security office, please bring this notice with you. If the decision in your case is based on incorrect information, we'll be happy to make whatever change is necessary.

YOUR RIGHT TO APPEAL

If you still are not satisfied with the decision, you may request a hearing of this decision by the Office of Hearings and Appeals. You must request the hearing in writing within 60 days from the date you receive this notice.

Appeal Within 10 Days If you Want The Prior Payment Continued

If you want your prior payment continued until the hearing is completed, you must request a hearing in writing within 10 days of receiving this notice. If you request a hearing within 10 days, we will continue or reinstate the prior payment until a hearing decision is made, no matter how long it takes. Depending on the outcome of your appeal, you may have to pay back any money you were not entitled to receive. For this reason, you may want to waive continuation of reinstatement of the prior payment; then, if you are successful on appeal, any money due you will be paid.

If you cannot send us a written request for a hearing within the 10 or 60 day time limits, be sure to contact us by phone. If you wait longer than 10 days, we will not reinstate the prior payment unless you have good reason for the delay. And, if you wait longer than 60 days and do not have good reason for the delay, we will not conduct a hearing review of our decision.

If you request a hearing, your case will be assigned to an administrative law judge of the Office of Hearings and Appeals. He/She will let you know when and where your case will be heard.

The hearing proceedings are informal. The administrative law judge will summarize the facts in your case, explain the law, and state what must be decided. Then you will have an opportunity to explain why you disagree with the decision made in your case, to present additional evidence and to have witnesses testify for you. You can also request the administrative law judge to subpoena unwilling witnesses to appear for cross-examination and to bring with them any information about your case. You have the right to request the administrative law judge to issue a decision based on the written record, without you personally appearing before him/her. You may submit additional written evidence for the administrative law judge to consider. The administrative law judge will base his/her decision on the evidence in your file plus any new evidence submitted.

In having your case heard, you can represent yourself or be represented by a lawyer or any other qualified person. Contact your social security office for names of organizations that can help you.

5

St. Paul-Ramsey Medical Center

640 Jackson Street Saint Paul, Minnesota 55101 (612) 221-3456

PSYCHIATRIC DISCHARGE SUMMARY

PATIENT'S NAME AND HOSPITAL NUMBER: [redacted] Charles [redacted]

ADMISSION DATE: 11-15-81

DISCHARGE DATE: 12-3-81

HISTORY: The patient carries a diagnosis of seizure disorder and chronic schizophrenia and chemical abuse and marijuana. He was most recently hospitalized from 10-21 to 10-27-81. Apparently at that time he had been combative, although this has not been clarified He was begun on weekly Prolixin shots 37.5 mgs. and discharged to his apartment where he was to get the injections by Public Health Nurse. He was also discharged on 500 mgs. Dilantin per day. It is not clear whether he got all his shots and it is possible he missed a couple of them; in any event, he presented to the Emergency Room, saying he was hearing voices telling him to kill himself and to play with himself. He was quite agitated when he was admitted. Apparently one time he had pointed a knife at his abdomen prior to admission but decided to come to the hospital instead. The patient does have a history of at least 15 admissions to St. Paul-Ramsey. Seizures are the grand mal type. The patient states he has been sleeping well and abuses no street drugs except for, as stated before, marijuana. Charles eats two meals per day and has a strong appetite. He has been going to bed at approximately 10:00 in the evening and awaking at 4 a.m. and then sleeping until 9 a.m. the next day. The patient has virtually no job history. He has been living in his own apartment since June, 1981, but the admissions showed an increase in admissions since his independent living.

PAST PSYCHIATRIC HISTORY: The patient has a history of drug abuse back to at least 9-74. He was hospitalized here for Dilantin overdose in 12-77 at which time he was felt by Psychiatry to be possibly paranoid schizophremic, possibly organic brain syndrome, and possibly hallucinating secondary to drug abuse and possibility personality disorder. In 1-78 he had an I.Q. documented of 86. In 3-79 he was admitted for paranoid schizophrenia and Dilantin toxicity. It was noted he was living at Central Manor at that time and had previously been hospitalized at Mounds. Most recent admissions include 5-7 through 5-18-81; this was possibly at Mounds under Dr. Raaunhorst or possibly here; we don't have a discharge summary on it. He was hospitalized here from 8-17 to 9-21-81 with overdose on Dilantin and psychiatric problems related to his paranoid schizophrenia. He was next hospitalized from 10-21 to 10-27-81 as noted above.

PAST MEDICAL HISTORY: The patient has a seizure disorder extending back to about age 3.

FAMILY HISTORY: Father murdered his mother and committed suicide; other than that there is no clear family history.

SOCIAL HISTORY: The patient has seven siblings; six brothers and one sister. At age 7 his father murdered his mother and suicided. It is unsure whether the patient witnessed this or not. He does not remember this at this time. When his father killed his mother and then committed suicide, as stated before, he was only 7 years old. The patient was then reared by his aunt. The patient's history in secondary and elementary school is negative as far as disruptive behavior is concerned. The patient states he was graduated from Central High in St. Paul in 1976. He appears to be marginally retarded. Last year Charles was arrested for assaulting a female he was staying with. It is unclear as to the disposition of the case, but nevertheless he was released. 5

MENTAL STATUS: The patient was a reasonably groomed black male with a bruise to the left of his eye which he says is from a seizure about two weeks ago. His behavior was abnormal in that he had frequent movements of the hands such as rubbing them together. His tongue was tremulous and on occasion he got up to walk as though he was overmedicated. He related in a cooperative fashion; speech showed an occasional stutter but was otherwise was coherent. Mood on any scale from 0 to 100 was rated as 48; affect was generally congruent with this. He did not appear to be severely depressed. Thought content revealed positive auditory hallucinations but no clear delusions. He denied being suicidal at this time. Sensorium examination showed he was oriented times three; he recalled ~~two~~/three objects at five minutes and confabulated on the others. He knew Presidents Reagan to Nixon in order. He could do serial seven's back to 79. Similarities were adequate; he was able to do proverbs; judgment by testing was adequate. He could not name cities, naming California, Miami, Florida and Texas. As stated before, when asked about proverbs, the patient apparently thought the proverbs were too abstract, simply stating that they were just sayings to him.

LABORATORY & XRAYS: SMA-6 and 12 were within normal limits. RBC, hematocrit, hemoglobin, MCV, MCH, and MCHC were all within normal limits. Also within normal limits was the platelet count ranging from 348,000 to 287,000. WBC's were normal. The Dilantin level was within normal range on 11-16 and at that time the Dilantin level was 11.5. Toxicology Screen was negative. Urinalysis was also negative.

HOSPITAL COURSE: After Charles was admitted on 11-15 and interviewed on 11-16-81 we merely proceeded to stabilize the patient on Prolixin and Dilantin. Dilantin levels as stated before were within normal range and we immediately instituted the administration of Dilantin 200 mgs. q.a.m. and 300 mgs. Dilantin q.h.s. on 11-15-81. On 11-16-81 Prolixin Decanoate 25 mgs. I.M. was ordered and this was to be given every Friday, so the dosage was decreased from the previous dosage of 37.5 mgs. to 25 mgs. I.M.. On 11-26 Prolixin Decanoate was given before in the previously prescribed time because the staff felt he needed it at that time. On 11-30-81 at 9:00 in the morning because of extrapyramidal side effects, 50 mgs. of Benadryl were given I.M. to patient. On the same date, staff recommended that we institute a regular administration of Cogentin. At that time Cogentin 1 mg. p.o. b.i.d. was instituted. Our main concern with the patient at this time was to place him in a supervised environment such as Sayth House or in a board and care environment. We chose the former. In conjunction with Dwight Peterson, social worker, we were finally able to get a position at Sayth House. The patient was anxious and willing to go to Sayth House. A TELS was administered the patient and results indicated that the patient did indeed need a more supervised and structured environment. The patient is a chronic user of

(con't)

[redacted]
Page #3

marijuana and this was stated in advance to Sayth House, however, Sayth House felt they could manage the patient even with his chronic habit. We had tried earlier in a consultation with ADAP in order to help the patient with his chemical abuse problem, but ADAP felt that he was not a good candidate at the time because he had no remorse nor any intention of changing his environment or use of marijuana.

FINAL DIAGNOSIS:

1. Schizophrenia, paranoid, chronic.
2. Seizure disorder.
3. Chemical abuse.

DISPOSITION: He was discharged to Sayth House at 470 Grand Avenue, St. Paul. He was referred to CPC and had an appointment scheduled for 12-18-81 at 10:30 a.m. with Dr. Landbloom. In addition, the patient has also an Urology consultation in December, date still pending. Also there was a disposition to the Public Health Nurse and she would administer his Prolixin shot 25 mgs. I.M. on 12-4-81 and thereafter.

DISCHARGE MEDICATIONS:

1. Dilantin 200 mgs. p.o. a.m. and 300 mgs. p.o. q.h.s..
2. Prolixin Decanoate 25 mgs. I.M. q. week one vial, no refills. To be administered by Public Health Nurse.

Dictated by:
Robert Rodriguez, Medical Student

Psychiatric Service

12-7-81/jao, CMT

St. Paul-Ramsey Medical Center

640 Jackson Street Saint Paul, Minnesota 55101 (612) 221-3456

PSYCHIATRY DISCHARGE SUMMARY

NAME: [redacted] CHARLES --[redacted]
DATE OF ADMISSION: 5-06-81
DATE OF DISCHARGE: 5-18-81

HISTORY OF PRESENT ILLNESS: This is the 12th St. Paul-Ramsey Hospital admission for a young black male with a long history of seizure disorder which is secondary to brain surgery at age 3. The patient also has a history of mental retardation and schizophrenic illness. The patient's last seizure was 10/80 and he is followed in Neurology Clinic.

The patient had been living with his brother until four months ago when he had a fight with his brother and sister. He then moved to the mission home where he has been living since. He began hearing voices telling him he is bad and "negative" and was started on Prolixin IM 25 mg. q.weekly. The patient's aunt visited him on the day of admission and noted that the patient had much trouble with side effects of medication and brought him to the Emergency Room because of this. She was quite upset over the medication side effects and refuses to take the patient back to the mission. She doesn't feel she can take care of him at home either, as he wanders away and gets in alot of trouble.

PAST HISTORY: Patient has a history of numerous placements in various homes and board and care facilities. The patient frequently gets in fights and arguments. The patient was first seen here at St. Paul-Ramsey in 1979 when he was treated with Stelazine 5 mg. t.i.d. for persistent auditory hallucinations. At the time of admission the patient was taking Diphenylhydantoin 200 mg. p.o. q.a.m. and 300 mg. p.o. q.h.s. He was also receiving Prolixin IM 25 mg. q.weekly. The patient has no history of significant medical problems. He has no history of surgeries and no allergies.

PHYSICAL EXAMINATION: The patient is a well developed, well nourished black male who at the time of admission had masked-like facies and was drooling from the mouth. He was exhibiting a tremor of the head and upper and lower extremities. The remainder of the physical examination was within normal limits apart from dry skin and diffuse ecthyosis which spares the flexions of the upper and lower extremities and the face. The neurological exam was unremarkable apart from 2+ cogwheeling of the upper extremities.

MENTAL STATUS: The patient was alert and oriented and cooperative. He was slow to respond. His speech and motor activity were slowed. His facial expression was mask-like with decreased range and appropriate. The patient's thought content was composed of auditory hallucinations. He described the voices as negative in tone, but could not be specific as to their content. There was no flight of ideas or looseness of associations. The patient denied suicidal ideation or phobias. He denies depression.

LABORATORY DATA: The initial laboratory studies including CBC with differential, urinalysis and SMA-6 were entirely within normal limits. The admission Dilantin level was subtherapeutic at 7 mcg/dl.

PSYCHIATRY DISCHARGE SUMMARY
[redacted] CHARLES

COURSE IN HOSPITAL: The patient was initially quell and remained superficial and pleasant spending much of his time in bed in his room. He was treated with anticholinergic medication and soon became less stiff and more comfortable with an increase of the Cogentin to 2 mg. b.i.d. His Dilantin level was only 7 mcg/dl on 5 mg. per day and a question of medication non-complianc entered the picture.

Throughout the hospitalization the patient continued to complain of auditory hallucinations although he could not be specific as to the content of the auditory hallucinations, he stated that the voices were saying "bad things" about him and were very negative in tone. The patient was also somewhat sexually preoccupied during the hospitalization, several times smiling and stating that he needs to "get with women".

During a family meeting with Charles' family it was decided that Charles should be moved to the care of Dr. Rauenhorst at United Hospital since Dr. Rauenhorst is his private psychiatrist on an outpatient basis. It was decided that it would be better for Charles to be moved to this other hospital and evaluated there for adjustment of his IM antipsychotic medication. He was happy to be transferred to the other hospital and the family was quite in agreement with this plan.

FINAL DIAGNOSIS:

1. Schizophrenia, paranoid, chronic with acute exacerbation. 295.34.
2. Seizure disorder. 345.9.

The patient's side effects from previous antipsychotic medications improved markedly during the course of hospitalization. His seizure disorder appears to be well controlled on 500 mg. of Dilantin daily.

DISPOSITION: The patient was transferred to United Hospital's locked ward under the care of Dr. Rauenhorst. He was also referred to Dr. Rauenhorst for outpatient followup.

DISCHARGE MEDICATIONS:

1. Thorazine, 100 mg. p.o. q.h.s.
2. Dilantin, 200 mg. p.o. q.a.m. and 300 mg. p.o. q.h.s.
3. Cogentin, 1 mg. p.o. b.i.d.

Dictated by:

Medical Student: Andrew Jamieson
Staff: William Miller, M.D.
Psychiatry Service
5-20-81 jb

William E Miller

Mr. SHANNON. Thank you, Mr. Harris. Perhaps I could ask a couple of questions.

First, you have skirted—or not skirted, but you have not testified as to whether or not you think that there is really in effect some kind of quota that is being applied. Is that what we are talking about here?

Mr. HARRIS. I have no doubt that the intent of the accelerated CDI process adopted by the administration in March 1981 and the profile CDI's was an effort to try to remove people from the rolls as quickly as possible. I have called it a cynical intent indeed because I feel sorry for those people who have been hurt, and there are people being hurt.

There is another problem with it. The administration in doing that has crippled the State agencies' ability to process their claims timely. And in the result the State agencies are not meeting the statutory goals that have been set down for them.

Mr. SHANNON. In your written statement you recommended that the career examiner program be developed. Now as I understand it there is a problem for staff attorneys to move up to the administrative law judge level. Is that a problem in keeping a very professional examination force in place in the whole process here? Would that help in some way to solve the problem you have testified about?

Mr. HARRIS. I will tell you what we were thinking about. We wanted to give you some alternatives to the proposals that you have about trying to bring some integrity to the ALJ process. That particular proposal, the theory we had after talking to line workers was that this would be an easier access for you to get ALJ's, which you are having a great deal of problem in getting; and it would be a way by which you could train ALJ's up front on the Social Security Administration's point of view. You are in effect indoctrinating them, even though in the end they are going to become independent.

I do not know whether that answers your question?

Mr. SHANNON. No. I think that the goal is to develop a much more highly professionalized system. That is not at all to disparage the people who are in the system now, because I think they probably are the best qualified Government employees I have dealt with. But to allow for promotion within the system to the point that I think will encourage more people to go in and to stay in that system

If I could just speak to the specific legislation, there are two proposals in the legislation that deal with ALJ autonomy. One is the proposal to make POM's applicable to all levels of the adjudicative process. The other is the proposal to close the record after reconsideration.

Would you like to comment on those?

Mr. HARRIS. Yes. Regarding closing the record after reconsideration, what troubles me about that is that most of the ALJ decisions are based on additional evidence. And most of that additional evidence comes from two places— the doctor's reports from the personal physician of the individual, which have less probative value perhaps than the consultative examinations, but it is important to the individual to feel like he is heard.

The second, and one of the most important ones I know of, is evidence regarding vocational rehabilitation. I fear that in cutting off the evidence at the recon level may cause some serious injustices. I also fear that it will result, as one person testified earlier, in a situation where you are going back and forth between the ALJ and the state agency to get more evidence.

I think that the integrity at the recon level is not in question. I think you have to expect that very few of the cases at that level are going to be reversed and made allowances. I do not think you can approach the problem and try to get at it in the way you are here.

I think your problem is with not having any sense of credibility with the ALJ system. I think what you can do there are largely administrative measures that will not undermine their essential independence. That then gets to the question of POMS.

Because of the problem of not knowing whether those regulations really are valid, because of the problems that some of these regulations are creating in the disposition of cases, I do not think you would be wise to promulgate them into law, which in effect you would be doing by telling to the judges: You must abide by them. That is what I fear. I think the judges should be free to be able to say: "The regulations and the law should be interpreted thus and such." Now if upon review of that kind of case the Social Security takes issue, fine.

If on the other hand the Social Security Administration says: "You have raised a bona fide policy issue," then obviously SSA should make a policy decision. I fear making the system less independent and more regulated.

Mr. **Shannon**. Mr. Rousselot?

Mr. **Rousselot**. Thank you, Mr. Harris, for a very good presentation, and especially as it relates to representing the workers in your union. You have certainly done that very well. As I understand, you represent 35,000 out of 72,000 Social Security workers?

Mr. **Harris**. Yes. Those are all the district office, branch offices.

Mr. **Rousselot**. 1,300 district and branch offices?

Mr. **Harris**. Yes.

Mr. **Rousselot**. So are there currently 72,000 Social Security workers nationwide?

Mr. **Harris**. Well, I think once you have added in management and such, I think we get up to a point of around 90,000.

Mr. **Rousselot**. 90,000. And you represent roughly, you said, 35,000, or half of 72,000?

Mr. **Harris**. Yes.

Mr. **Rousselot**. So you represent 35,000.

Mr. **Harris**. Yes.

Mr. **Rousselot**. You have done an excellent job of stating their case. I was very much taken by your statement that you say to us, the committee, that: As a union we have this timely manifesto. We can make Government more efficient and more effective if only you would listen to us.

That kind of implies that we ain't been listenin' to you. Is that right?

Mr. **Harris**. Yes.

Mr. **Rousselot**. So you are suggesting that this committee has not been listening to you?

Mr. **Harris**. Well, Mr. Rousselot——

Mr. **Rousselot**. "And that the worker is attacked and maligned by both in Government and out?" Is that correct?

Mr. **Harris**. Is it correct that that is happening? Yes.

Mr. **Rousselot**. Have you heard either one of us attacking workers? As a matter of fact, I find your workers in Monrovia, Calif., and El Hambre, Calif., very, very cooperative with our caseworkers in the district. So I do not know who is attacking you. Is this committee?

Mr. **Harris**. Well, it has been awhile since I have read your statement on the Civil Service Reform Act, but——

Mr. **Rousselot**. I wondered about that. Anyway, you also say that you submit that "he and he alone," that is the worker, "knows how this Government works or fails to work and ultimately you will need him." So that is what your basic statement is. It is kind of the bottom line of your statement, is it?

Mr. **Harris**. What I am trying to rouse your interest in——

Mr. **Rousselot**. You have it. You have my interest.

Mr. **Harris** [continuing]. Is the fact that the Social Security Administration is in very bad shape, and has been for over a decade, and it is worsening. And I believe that those of us who are out there where the rubber meets the road are the ones who can tell you exactly what it is that is going on and what is wrong.

Mr. **Rousselot**. Yes. Well, I guess that is why some of us, including the chairman, went up to Baltimore about a month ago. We went through the whole system as best we could in a day to see how it works and how it does not work, and listened to some of their comments on this whole subject. As a matter of fact, we saw how the records were kept for disability cases, to be specific, and there was only one folder for each recipient.

Now to follow through to make it clear to you that we are trying to listen, you mentioned that you had some thoughts about H.R. 5700, which is the bill before us, and you made a couple of comments in response to questions by my colleague from Massachusetts, Mr. Shannon. Are you going to submit for us specifics on H.R. 5700?

Mr. **Harris**. Yes.

Mr. **Rousselot**. You have not done it here. You kind of generalized here.

Mr. **Harris**. Right. I was not able—I still have not been able to get ahold of a copy of this.

Mr. **Rousselot**. Let me be the first to present you with a copy.

Mr. **Harris**. Yes. I would be very happy to try to assess, especially administrative impact, as well as give you my gut reactions.

Mr. **Rousselot**. I think that would be helpful, since that is the main purpose of this hearing, to see what we should or should not be doing with H.R. 5700.

I am sure you are aware of the General Accounting Office report of March 3, 1981, to the Congress. The general summary is that a more diligent followup is needed to weed out ineligible SSA disability beneficiaries. And then the general statement is that as much as $2 billion annually in social security disability insurance payments may go to individuals who are no longer disabled.

Are you familiar with that report?

Mr. HARRIS. Oh, yes.

Mr. ROUSSELOT. Could you respond to us the specifics of that report where you think they are either correct or incorrect?

Mr. HARRIS. That report was based largely on data obtained by a quality assurance review.

Mr. ROUSSELOT. Right.

Mr. HARRIS. That was so-called phase I of the review. They have now completed phase II, and they are into a new phase.

Mr. ROUSSELOT. And they closed some of our employees from Social Security in this report.

Mr. HARRIS. Well, Mr. Rousselot, I am not denying there are people on benefits who should not be on benefits. My concern is that when we did the analysis of what we thought of the people who were ineligible, we were finding new standards, new points of view.

Mr. ROUSSELOT. You made that point.

Mr. HARRIS. And I think that is where the difficulty is.

Mr. ROUSSELOT. Well, could you respond to the points in the documents? Just roughly a basic comment where you feel the Social Security Administration has not adequately followed up on disability insurance benefits?

Mr. HARRIS. Well, I know that is true. I also know why it happened. It happened because of staffing cuts, because of budget constraints——

Mr. ROUSSELOT. But, of course, this report was prior to March 1981. As a matter of fact, it goes back primarily to 1979-80. So those cuts had not occurred at that time.

Mr. HARRIS. Oh, no. The Civil Service Reform Act enacted a general Federal ceiling.

Mr. ROUSSELOT. 1977?

Mr. HARRIS. Yes.

Mr. ROUSSELOT. Could you comment on how you feel these points were either well taken, or not well taken, because it does relate to this legislation before us.

Mr. HARRIS. I would be glad to.

[The information follows:]

SECTIONAL ANALYSIS OF H.R. 5700

SECTION 2

The extension of benefit rights to Title II appealants whose disability benefits have been terminated is similar to the rights of those under title XVI but under H.R. 5700 would not extend through the hearing level of appeals. In contrast, title XVI benefits do extend through the hearing level.

Notwithstanding the provisions of Section 3 (Adjustment benefits) those Title II who appeal cessations to hearings levels will suffer great hardship. Moreover, as long as disability provisions are administered as they are, very few of those who file for reconsiderations will receive favorable decision. When you view this predicament in light of the questionable practices in disability determinations, you must wonder whether you are not prolonging the agony more than checking injustices in the system. For those who will make decisions on reconsiderations are those tho make the initial decisions; they shall use the same rules and, if those rules are invalid or unjust, then there is no equity in the system.

At lines 6-7 at page 3 you would accord the secretary the right to set procedures for electing continuance of benefits. Under Title XVI the appealant is given but 10 days to make such an election. We believe this is an unduly short period of time. To avoid that, I recommend that line 6 be amended as follows: "such individual may elect within a reasonable period of time . . . etc." A time limit by fiat (e.g. 30 days) is not recommended, even though 30 days seems reasonable, because sometimes an appealant may have good cause to miss such a time frame (Hospitalization, etc.).

In subsection 2(a) at lines 16 through 22 on page 3, you would in effect mandate recovery of these extended benefits without regard to the usual provisions of waiver of recovery. I recommend that the provision be amended to add at the end of these lines the following proviso: "absent a showing that it would defeat the purpose of Title II to recover the overpayment." These are words of art which by regulation carry with it a test of the financial ability of the beneficiary to repay the overpayment.

At line 11 on page 3 the extended benefits would terminate effective with the month before the month that a decision is made by reconsideration to terminate benefits. Because of all too common delays in the processing of notices and effectuation of decisions, this will result in circumstances where beneficiaries may have received and spent benefits to which he is not entitled. Accordingly I recommend you to change line 11 to read: "ending with the month in which a decision is made . . . etc." Since all such payments are overpayments anyway, this change simplifies administration. We also recommend that such extended benefits be continued through the hearings process and not terminate at the reconsideration level.

Notwithstanding other provisions in HR 5700, the disparity between ALJ and state agency decisions will continue so long as the various regulations (including the POMS) remain as dubious as they are in the eyes of the public, the medical profession and vocational rehabilitation specialists. Moreover, there will always be a rather large area of judgment and disagreement over judgment. While those who are on benefits are not entitled to indefinite benefits where once a disability was found which may have been ameliorated, they are entitled, we believe, to a presumption of disability where they have formerly met the rigorous tests of Social Security. For even with some lassitude in SSA quality assurance during 1973-1978, the vast majority of applicants were disallowed and we can tell you that outright fraud is still extemely rare in its sheer numbers. Almost all such fraud occurs when a beneficiary does not report SGA work. Your bill does nothing to advance the SSA efficiency to detect such illegal acts, and cessations due to SGA work activity are not granted extensions of benefits under section 2 anyway.

SECTION 3

With appropriate amendments described above, section 3 may not be necessary except in those cases where the individual does not appeal his cessation. As an incentive therefore to accept the SSA determination and to permit the individual time to "adjust" and find employment, your proposal seems very worthwhile. We would recommend, however, that these adjustment benefits be available only to those who do not file an appeal. We also recommend that all cessations be entitled to these, not just those long term beneficiaries (36 months or more).

We would concur, however, in a timely termination of this provision, subject to a report by SSA about the efficacy of this provision in enabling "adjustment". If such provision does encourage individuals not to appeal SSA's determination and does facilitate "adjustment", we would recommend its continuation. Our reason for recommending that adjustment benefits be permitted to all who would have their benefits ceased is because: this provides its broadest test for effectiveness; and the current high rate of cessation (approx. 45 percent of CDI's) is not different among those who have been on the rolls more or less than 36 months; and any cut off point is arbitrary without more data about the characteristics of these cessations.

SECTION 4

The intent of section 4 is to make cessations prospective in effect. As intent we agree with it but we would propose that language be simplifed and that it not expire on 1/1/85 as proposed. The section should simply provide that cessations will be effective with the month following the month of decision, absent a determination that the beneficiary failed to report a medical improvement which clearly resulted in his ineligibility.

SECTION 5

We oppose section 5 as it is proposed except for provisions of 5(d) which would establish a reconsideration for disability cessations, that is, an intervening step prior to hearings after a cessation by a state agency. We note, however, that this provision in 5(d) would add significant workloads to state agencies that are now unfunded. We also note that 5(d)(2)(B)(ii) would prescribe an evidentiary hearing at the recon level and that too would be burdensome without adequate funding. We wonder also whether this step should be taken until SSA has completed its current experiment on such evidentiary hearings, known as DARE, and has subjected that study to careful scrutiny.

As to closing the record we have already stated our misgivings. We repeat here that closing the record serves not the beneficiary so much as the administration and that the purpose of a full and open hearing is undermined by diminishing the appealant's rights.

SECTION 6

We are opposed to section 6. It is unnecessary to legislate a practice of quality assurance which on its face is good management. SSA does do its own motion review, as well as other quality assurance, and it would be unwise to mandate a practice which ought to be flexible so as to focus its objectives on specific and identifiable problems. For example, should our motion review be used as a general quality measure of individual ALJ's? Should it be used to identify apparent misapplications or disputes on interpretation of the regulations? These are fundamentally management functions.

SECTION 7

The reference to POMS should be deleted. If the ALJ decision is to be autonomous, it must not be dictated by standards of the secretary, such as the POMS, which are not statutory but instructional. Instructional material such as the POMS constitute mere interpretation of the statute and are not and should not be viewed as regulation governing the autonomous administrative review (ALJ) of the secretary's decision.

Section 8. No comment.

SECTION 9

We oppose this provision for the simple reason that those who would be disentitled from benefits as a result of this provision are without remedy in their loss of benefits. It is a concession without trade-off.

SECTION 10

The provision is long overdue and is equitable.

SECTION 11

Generally the provision is not necessary in statute. It is an act of appropriations and should be treated accordingly. However, we do endorse the concept of an Advisory Council on Disability but we would broaden its function to include the validation and promulgation of medical and also vocational listings which would hopefully better serve just determinations. The current regulations are not credible to the public or the professionals which they affect.

Section 12. No comment.

Section 13. No comment.

Section 14. No comment.

Section 15. No comment.

Section 16. No comment.

Section 17. No comment.

We were also asked to comment on the problems of the disability program, from the administrative point of view. Specifically, the impact of budgetary constraints.

In 1972 because of the crush of Black Lung claims SSA cut its 100% review of disability claims to 5 percent. Actually, given effective quality assurance and management controls, a reduction of review might not have effected quality but SSA's cut was so dramatic and so poorly planned that it caused claims quality to go out of control. That was because the act was an expedient; it was a matter of shifting our resources to the Black Lung backlogs which had become a national disgrace; many

Black Lung claims were 2 years old and SSA was awarding benefits twice to the same person on duplicate claims filed because the claimant thought the first claim lost. Perhaps because it was an expedient, perhaps for other reasons, SSA did not develope comprehensive instructions to the state agencies on processing disability claims independently. In fact it was not until 1978-79 that SSA issued comprehensive unifrom guidelines (POMS). In the meantime the state agencies were left to their own interpretations. Reorganizations in SSA compounded the problem. Regional offices established in the early 1970's took over program responsibilities in disability and this resulted in varying practices and instructions among the 10 regions. The lack of uniformity was already a problem when SSI was enacted and then because SSA failed to staff for the program the state agencies became suddenly backlogged. The need for dramatic increases in staffing over 1974-76 in the state agencies resulted in poorly trained staff who were pressed to do full workloads before they had developed journeyman expertise.

Again because of limitations on resources SSA adopted expedients which adversely affected the program. CDI's were deferred or cancelled. Medical reexaminations were cancelled for a long period in 1974-75 and some never were done.

As Congress began in 1978 to develop proposals to improve disability processing (ultimately resulting in the Disability Reform Act of 1980), SSA had begun to overcome its backlogs and impose new regulations to establish greater uniformity among the state agencies. But the years of deterioration in quality assurance gave rise to doubts about the elegibility of many beneficiaries. At the very least there was common sense that the program had permitted some who should have been subject to reviews to continue without test of their continued eligibility. Unscientific reports indicated that perhaps 20 percent of those on the rolls should be investigated.

Against this background Congress mandated a pre-effectuation review of claims and a continuing disability review for all on the rools whose disability was not permanent. Although these provisions were deliberately phased so as to provide SSA with an opportunity to gear up its resources, other acts of Congress and the Administration undermined sound management.

The Civil Service Reform Act froze federal employment and the administration of President Carter and Reagan both cut staffing. Hence although appropriations for fiscal year 1979 would have increased staffing by 1,200 positions in SSA, none materialized; in fact SSA has steadily lost staff since then.

To fulfill its mandates, SSA again adopted expendients, shifting workforce and deferring necessary work so to meet its work which was more immediate. Some of these expedients are in other program areas. But even in the disability program there were changes. Staffing in the central office disability operations was cut. Backlogs more than doubled. When SSA then focused on backlogs, initial claims took longer to process. Staffing siphoned off for pre-effectuation review and CDI's drained resources for the processing for initial claims and post entitlement events.

When the Reagan administration determined to accelerate CDI's in early 1981, they knew that there was not sufficient staff in either state agencies or SSA to do the job. They attempted to meet these limitations by eliminating the personalized disallowance notice and cutting back on pre-effectuation reviews. Indeed their fiscal year 1983 appropriation would eliminate funds for some of these activities and others. They also cut back on quality assurance; they eliminated all reviews of disability cessations; they cut back reviews of disability denials; they eliminated front-end medical reviews of cases under quality assurance samples. So it now stands.

SSA projects that in fiscal year 1982 they will cut fulltime staff by 2,500 and in fiscal year 1983 they will cut their part-time staff by 2,800. To achieve these cuts they will adopt additional expedients including the deferral of development of spouse and children benefits for disability applicants and other actions which will result in dramatic increases of time it takes to make payment to the disabled and their families.

We are also advised that the state agencies will take much more time to process initial claims, delays of 2 to 4 weeks are common, because the workload of CDI's is not met with sufficient resources. In so far as this affects quality, it appears that the error will increase in disallowances where before it was said that error increased in allowances. This is because the focus of quality assurance is on cases where state agencies allow benefits, rather than a general cross section which would of necessity constitute a 70 percent to 85 percent ratio of disallowances. Thus, the state agencies complain of a "climate of adjudication" in which allowances are viewed as a threat to the institution of the state agency itself; for mistakes on allowances can result in federalization of the agency under the secretary's rules.

Mr. **Rousselot**. I was also interested in your comment that CDI has become a monster. You have stated that. Can you be a little more specific on that? You related to it briefly in your testimony, but could you be more specific on why it is a monster.

Mr. **Harris**. You remember, I think you asked one of the people about the 600,000 people who were mentally ill.

Mr. **Rousselot**. I can be very exact. I asked about the two categories covered by social security law. One is mental retardation, with 329,000 in the program now. And two is mental illness, with 629,000.

Mr. **Harris**. I think what we are going to find is that easily over 50 percent of those people are going to be cut off over the next 2 years.

Mr. **Rousselot**. Fifty percent?

Mr. **Harris**. It is a higher—they are finding higher rates of ineligible——

Mr. **Rousselot**. On the basis of the CDI monster, as you called it?

Mr. **Harris**. Yes.

Mr. **Rousselot**. OK. Can you back that up with some kind of input from your people who work in that field?

Mr. **Harris**. The only data that I—yes.

Mr. **Rousselot**. Thank you.

Mr. **Harris**. All I have now is just anecdotal data on what appears to be happening. The statistical data, I do not think the SSA has broken it out yet, except in terms of their phase I and their phase II material. So I will get those for you.

Mr. **Rousselot**. That would be helpful.

[The information follows:]

We were asked to assess the impact of CDI's on the current beneficiary.

In fiscal year 1982 SSA has planned 567,000 CDI's from the rolls; there are an additional 229,000 CDI's which result from reports of beneficiaries and medical reexaminations. In fiscal year 1983 SSA has planned 806,000 CDI's from the rolls; there are an unknown additional number of CDI's which are expected to result from beneficiary reports and medical reexaminations.

All in all during the two year period 10/81-9/83 we are expecting over one and a half million disabled persons to undergo reviews.

Even though SSA's preliminary findings evidence that perhaps 20 percent of those on the rolls would be found ineligible, the budgeted expectation by OMB is a 50 percent rate of ineligibility and in fact the disabled are currently being terminated at the rate of about 45 percent. In sheer numbers one can therefore expect that between 720,000 and 800,000 persons will be terminated from benefits over this period. This contrasts with a total of 75,876 terminated because of CDI's in 1980.

It is an immense tragedy before you. Surely some of this is the result of sheer volume increase in CDI's. SSA proposes to increase their CDI output 400 percent over this period from its base rate during the late 1970's. But we are also seeking CDI's on individuals which formerly were not subject to CDI's. Over and above those working and those who were expected to recover, SSA is now looking at those whose disability was so severe that no recovery was expected. These are basically persons who have been on the rolls more than three years and whose medical condition was not expected to improve over the first three years or was expected to end in death and hence it appeared the disability was "permanent", and no reexaminations were scheduled. Our experience with quality assurance studies in 1980-81 now show that if we apply current standards, many of these are not eligible. For some of these we are observing advances in medical science (e.g., bypass surgery has reduced the severity of disability due to arteriosclerotic disease). But it appears that the largest numbers—diagnosed with orthopedic, musculo-skeletal and mental listings—are cases in which the application of new listings (medical and vocational) reverses our original decision, or are cases in which a condition is arrested by some treatment and current regulations would seem to show some residual capacity for work. There also seem to be a small percentage of cases (neoplasms, neurological disease) in which remissions have occurred.

What we conclude from this is that "recovery" from disability cannot be viewed as it was narrowly in the past—in terms of immediate expectations of relatively short-term periods of disability (less than three years). We must also consider whether advances in medical science, remissions, or arrested conditions can enable a disabled person to recover. We are looking then at identifiable syndromes which may require reexaminations in a 3 to 5 year period.

In our view, however, the tragic consequences of the application of new rules to old disability determinations under the current "climate of adjudication" will wash away the sound objectives of a CDI program. We are witnessing a savage purge of the rolls, with mean applications of self-serving rules, and without heart or mind to the consequences.

Mr. ROUSSELOT. Now you were here, I am sure, when Mr. Gibson testified, were you not?

Mr. HARRIS. Yes.

Mr. ROUSSELOT. He is with the Social Security advocates in Phoenix, Ariz. He said that a clean-cut, three-level system would be more workable, starting with a fairer, more thoughtful initial determination step. He said we need to reorganize the bureaucracy to arrive at a clean-cut, three-level system.

Are you familiar enough with his statement to comment?

Mr. HARRIS. Well, frankly I have a feeling that he was objecting to own-motion review.

Mr. ROUSSELOT. Yes, he was.

Mr. HARRIS. And I have——

Mr. ROUSSELOT. I would say that is a safe assumption.

Mr. HARRIS. Yes. And I have a feeling that that is a necessity of quality assurance to have——

Mr. ROUSSELOT. Well, would you be kind enough to review his statement and comment on it?

Mr. HARRIS. Yes.

Mr. ROUSSELOT. He made a pretty positive statement that we would be a lot better if we had a clean-cut, three-level system. Since that might eliminate some employees you represent, I thought you might want to comment on that.

[The information follows:]

We were asked to comment on a proposal to make a "clean-cut, three-level system."

Notwithstanding Mr. Rousselot's comment, we do not fear that Congress could expedite appeals in such a way as to threaten SSA worker security because you do not have enough workers to do the job right anyway. Moreover, the necessity for a more effective quality assurance would require increased staffing lest you condone deterioration of public service by the use of expedients to cut out other necessary public services.

Own motion review is apparently opposed because it would interfere with the ALJ autonomy but it is reasonable to provide some own-motion review as a normal practice in quality assurance. We are concerned here only that this review is used solely as a measure to cut ALJ allowances, and not, as it should be, to focus on critical policy and program issues.

I do not believe, in answer to Mr. Rousselot's question, that there is any way to "streamline" the appeals process without curtailing quality assurance or jeopardizing the rights of appealants. I do believe, however, that if the State agencies were permitted to apply disability regulations with more judgment and balance, the rates of appeals would go down and ALJ reversals would fall.

Mr. HARRIS. Well, sir, I will tell you. You could do a lot to the Social Security program and you still do not have enough workers.

Mr. ROUSSELOT. You think we need more?

Mr. **Harris**. Not necessarily. You just need a whole lot better management.

Mr. **Rousselot**. Well, I am sure I have exhausted my 5 minutes.

Mr. **Shannon**. You may have more time if you want, Mr. Rousselot.

Mr. **Rousselot**. Well, I hate to put Mr. Harris through a lot of unnecessary hoops here.

Mr. **Harris**. Thank you.

Mr. **Rousselot**. Thank you for your testimony.

Mr. **Shannon**. Thank you, Mr. Rousselot.

Thank you, Mr. Harris, and we will look forward to the further material that Mr. Rousselot has requested. I am sure that will keep you busy for the next several days. We appreciate very much your testimony.

This hearing will recess until tomorrow morning at 9:30 in this room. Thank you very much.

[Whereupon, at 2:40 p.m., the subcommittee adjourned, to reconvene at 9:30 a.m., Wednesday, March 17, 1982.]

DISABILITY AMENDMENTS OF 1982

WEDNESDAY, MARCH 17, 1982

House of Representatives,
Committee on Ways and Means,
Subcommittee on Social Security,
Washington, D.C.

The subcommittee met at 9:37 a.m., pursuant to notice, in room B-318, Rayburn House Office Building, Hon. J. J. Pickle (chairman of the subcommittee) presiding.

Chairman Pickle. The committee will come to order. This is the second morning of hearings on H.R. 5700, the Disability Amendments of 1982. We have several witnesses this morning.

The first is our colleague from Missouri, the Honorable Ike Skelton. We are pleased to have you here, Congressman, and we will ask you to proceed with your statement. I see you do not have a long statement. Do you wish to follow it or do you wish to summarize it?

STATEMENT OF HON. IKE SKELTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. Skelton. Mr. Chairman, I will briefly go through my statement. First I would like to thank you for the opportunity to be with you to testify here on H.R. 5700.

It addresses a problem that is distressing to me and many. I am referring to the overzealous and irresponsible actions of the Social Security Administration in conducting their reviews of continuing disability insurance claims.

Their actions were brought to my attention in a very personal and a very vivid way when my offices in Missouri started to receive an inordinate number of calls and letters from people who had received termination of benefit notices and from others who became fearful for their benefits after hearing reports of the Social Security Administration's investigations.

Mr. Chairman, in the past 9 weeks alone I have opened cases on 18 people in my district who have been receiving social security disability and have recently lost their benefits. This number may not be startling to you, but to me this is a new and it is a frightening phenomenon. This type of case was not common during the past several years. More importantly, when you see the people who are having their benefits cut, you realize how inexcusable some of these termination decisions are.

Let me share with you some of these stories. One person suffers from heart problems related to diabetes and experiences sudden loss of blood pressure. His doctor believes that he may face sudden death if he returns to work.

Another has lupus, hypertension, and a ruptured disc. He also has complications from the five medications he is currently taking. His family physician for the past 17 years confirms the continuation of his disability.

A third suffers from severe mitral valve insufficiency. He underwent open heart surgery twice in 1980, and has been hospitalized three times in the last 6 months. He also suffers from urological problems. He was never examined by a Social Security Administration physician, yet he was informed that his benefits would be terminated because evidence in his SSA file showed he should be able to stand and walk for up to 6 hours per day and lift 25 pounds.

Another suffers from chronic lung disease, cancer, bursitis and anemia. Her doctor believes that she is completely and totally disabled.

Another constituent is a heart patient with a long history of problems. He is also visually impaired. A letter from his doctor states that the activities of going to and from work are sufficient to develop heart failure. Mr. Chairman, his doctor, by the way, is the director of cardiovascular diseases at Kansas University Medical Center.

All these people have been notified that their benefits will be terminated. They all have the right to appeal. However, they will have to make do without their benefit checks until their cases are reconsidered.

Their social security disability insurance benefit checks make up a significant part of their monthly income. The loss of this money will present major financial hardships for these people, who have large medical expenses in addition to the usual expenses which we all have for food and housing.

I feel that these accounts represent some basically imprudent and callous decisions on the part of social security. Beneficiaries are not the only persons, Mr. Chairman, contacting my office expressing concern about disability terminations. A social security district manager in my district in Independence, Mo., has provided me with a memorandum in which he accuses the Social Security Administration of ignoring the opinion of an eminent cardiologist in its fervor to accomplish its mission.

I would at this time, Mr. Chairman, wish to read this memorandum which has been furnished to me. It is a memorandum to John J. McDonald, regional commissioner, Kansas City, Mo., from Donald C. Smith, district manager, Independence, Mo., of the Social Security Administration, subject DIB cessations:

> As you know, DIB cessations have become big news. At least three-fourths of the congressional inquiries that cross my desk concern DIB cessations. At least three-fourths of the cessations are cases involving heart impairments. In many cases, the medical material submitted by the HA—or the hearing agency—would indicate denial is incorrrect.
>
> Today, within a matter of minutes, I handled two DIB cessation congressional cases that bore remarkable resemblance. In both instances, the file contained a letter from Dr. Gerald B. Lee, M.D., which indicated his disagreement with the proposal to cease benefits. Dr. Lee is an eminent cardiologist and DDU—or disability determination unit—is apparently ignoring his opinion in its fervor to do whatever it is trying to accomplish. Copies of Dr. Lee's letters are attached.

It is difficult to understand how the SA—Social Security Administration—can overlook or overcome these letters. Whatever the motive, we are witnessing wholesale mishandling of these CDI's, creating much needless hardship. The high reversal rate at the hearing level bears this conclusion out quite graphically.

Another byproduct of these wrong cessations and one that will strangle all of us is the tremendous backlog of cases in OHA that will logically result. In many of the letters I read, claimants blame their problems on the present administration. I have not seen any effort made to correct these erroneous impressions. Certainly the present administration did not legislate the current rate of review. Whether the SA's have a cessation quota or not, I do not know. One might infer that there might have been guidelines which would account for the current situation.

The assistants in Representative Skelton's office deplore the present high incidence of DIB cessations. I concur in this. Someone is going to have to take quick and effective measures to curb this or we are going to mire helplessly in pending appeals which will be all but meaningless due to the ponderous backlogs.

Mr. Chairman, I could go on concerning this entire situation, but I think that this letter from the District Director to his superior sums it up far better than I could do it. I think that this bill, H.R. 5700, is designed to help alleviate at least part of this situation and it would give, as I understand it, those people who are in this precarious situation during that time of appeal the continuation of those benefits.

I hope that this committee will see its way clear to correct these problems because there are some people out there who are in need. Physicians, eminent medical witnesses, say that they are in need. They want to work but they are unable to, according to their own physicians.

I certainly hope that we can do our best to alleviate this situation so that it will not occur in the future. I do ask, Mr. Chairman, unanimous consent that my entire prepared statement be provided in the record.

Chairman PICKLE. It will be included, Mr. Skelton.

[The prepared statement follows:]

STATEMENT OF HON. IKE SKELTON A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. Chairman and members of the Subcommittee, I would like to thank all of you for providing me with the opportunity to testify here today on H.R. 5700 which addresses a problem that is very distressing to me and to the people of Missouri. I am referring to the over zealous and irresponsible actions of the Social Security Administration in conducting their reviews of Continuing Disability Insurance claims. Their actions were brought to my attention in a very personal and vivid way when my offices in Missouri started to receive an inordinate number of calls and letters from people who had received termination of benefit notices, and from others who became fearful for their benefits after hearing reports of the Social Security Administration's investigations.

In the past nine weeks alone, I have opened cases on eighteen people in my District who had been receiving Social Security and have recently lost their benefits. This number may not seem startling to you, but to me, this is a new and frightening phenomenon. This type of case was not common during the past several years. More importantly, when you see the people who are having their benefits cut, you realize just how inexcusable some of these termination decisions are. Let me share with you some of these stories.

"One person suffers from heart problems related to diabetes and experiences sudden loss of blood pressure. His doctor believes that he may face sudden death if he returns to work.

"Another has lupus, hypertension, and a ruptured disc. He also has complications from the five medications he is currently taking. His family physician for the past 17 years confirms the continuation of his disability.

"A third suffers from severe mitral valve insufficiency. He underwent open heart surgery two times in 1980, and has been hospitalized three times in the last six months. He also suffers from urological problems. He was never examined by a Social Security Administration physician, yet he was informed that his benefits would be terminated because evidence in his SSA file showed that he should be able to stand and walk for up to six hours per day and lift 25 pounds.

"Another suffers from chronic lung disease, cancer, bursitis and anemia. Her doctor believes that she is completely and totally disabled.

"Another constituent is a heart patient with a long history of problems. He is also visually impaired. A letter from his doctor states that the activities of going to and from work are sufficient to develop heart failure. His doctor, by the way, is the Director of Cardiovascular Diseases at Kansas University Medical Center."

All of these people have been notified that their benefits will be terminated. They have a right to appeal, however, they will have to make due without their benefit checks until their cases are reconsidered. Their Social Security Disability Insurance benefit checks make up a significant part of their monthly income, and the loss of this money will present major financial hardships for these people who have large medical expenses in addition to the usual expenses which we all have for food and housing. I feel that these accounts represent some basically imprudent and callous decisions on the part of Social Security.

Beneficiaries are not the only individuals contacting my offices expressing concern about disability terminations. A Social Security District Manager in my district has provided me with a memorandum in which he accuses the Social Security Administration of ignoring opinion of an eminent cardiologist in its fervor to accomplish its mission.

He writes "Whatever the motive, we are witnessing wholesale mishandling of these CDIs, creating much needless hardship . . . Another by product of these 'wrong cessations', and one that will strangle all of us, is the tremendous back-log of cases in appeal that will logically result."

For the past year, the Social Security Administration has been forwarding 30,000 SSDI cases per month to their state offices for review. On the surface, one would think that this rate of review would represent the well oiled action of an efficient government machine. Upon closer scrutiny, however, one discovers that almost two thirds of terminated SSDI cases need to be reinstated after the cases are appealed. Deeper insight into the personal lives of those who were subjected to this inquisition, reveals major financial hardship during the months they had to go without their checks. Their financial problems are aggravated by the cost of the legal fees which they end up paying to defend their benefits.

Mr. Chairman, I have always been a strong supporter to Social Security. I voted in favor of the Social Security Disability Amendments of 1980 because I felt that they made some important and long overdue changes in the Social Security Disability program. One of the provisions of that act was a required review of all non-permanent disability cases every three years and of all permanent disability cases every seven years. This was a change in the law which needed to be made. No one wants to see benefits going to unqualified people. Unfortunately, in a blind effort to reduce government spending, the Administration acted prematurely, and began its review process without taking the time to develop a system that provided accurate evaluations and valid terminations. The result has been unnecessary financial hardship for thousands of disabled workers.

I am pleased to see this legislative effort to address many of the problems which have resulted from this review process. H.R. 5700 would make a variety of necessary changes, however, I am particularly interested in the provision which would continue SSDI benefit payments during the appeals process. In light of the high rate of reversal of terminations, this seems to be a fair way of reducing the financial burden of qualified beneficiaries who have their benefits challenged. Furthermore, I support the bill's provisions which lengthen the appeal time from two to six months and provide for face to face hearings during reconsideration.

Getting federal spending under control will always be a key factor in the legislative decisions I make on behalf of the people of the Fourth Congressional District of Missouri. I am sure that most of you hold this same commitment. However, we must not approach this objective in a manner which results in the needless suffering of qualified Social Security Disability beneficiaries. These people paid into Social Security when they were able to work, and would really rather be working now if they could. Unfortunately, because of serious injuries or progressive degenerative diseases, they simply can't work. We have an obligation to pay them the benefits which they qualify for. To do otherwise would undermine the integrity of the Social Security Disability program.

Thank you for this opportunity to speak on behalf of H.R. 5700. I look forward to the success of this legislation and to a more equitable review process for SSDI beneficiaries.

Chairman PICKLE. Do you also wish the letter you just read to be made part of the record?

Mr. SKELTON. Yes, I do.

Chairman PICKLE. It will be.

[The letter referred to follows:]

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
February 25, 1982.

To: John J. McDonald, Regional Commissioner, Kansas City, Mo.
From: Donald C. Smith, District Manager, Independence, Mo.
Subject: DIB Cessations.

As you know, DIB cessations have become big news. At least three-fourths of the Congressional Inquiries that cross my desk concern DIB cessations. And, at least three-fourths of the cessations are cases involving heart impairments. In many cases, the medical material submitted by HA would indicate denial is incorrect.

Today, within a matter of minutes, I handled two DIB cessation Congressional cases that bore remarkable resemblance. In both instances, the file contained a letter from Dr. Gerald B. Lee, M.D., which indicated his disagreement with the proposal to cease benefits. Dr. Lee is an eminent cardiologist and DDU is apparently ignoring his opinion in its fervor to do whatever it is trying to accomplish. Copies of Dr. Lee's letters are attached. It is difficult to understand how the SA can overlook and or overcome these letters. Whatever the motive, we are witnessing wholesale mishandling of these CDIs, creating much needless hardship. The high reversal rate at the hearing level bears this conclusion out quite graphically.

Another by product of these "wrong cessations", and one that will strangle all of us, is the tremendous back-log of cases in OHA that will logically result. In many of the letters I read, claimants blame their problems on the present administration. I have not seen any effort made to correct these erroneous impressions. Certainly the present administration did not legislate the current rate of review. Whether the SA's have a cessation quota or not, I do not know. One might infer that there might have been guidelines which would account for the current situation.

The Assistants in Representative Skelton's office deplore the present high incidence of DIB cessations. I concur in this. Someone is going to have to take quick and effective measures to curb this or we are going to have to take quick and effective measures to curb this or we are going to mire helplessly in pending appeals which will be all but meaningless due to the ponderous backlogs.

Chairman PICKLE. The committee is mindful of the large number of people who have been brought into the social security office for review. There has been an enormously large number and I question whether the social security office is prepared to handle this large number, and certainly we are concerned about the high rate of denials that are issued—upward of 40 to 45 percent in this first flow of interviewees.

The bill we have before us is designed to slow that process down and approach the review in a more humane and fair manner. What has happened in your district has happened in many congressional districts over the Nation. This is one reason why we have advanced the bill to try to slow this thing down.

I was particularly pleased to note that you had voted for the Social Security Act of 1980. It was designed to correct some of the faults we had in the system. Now we are going to have to take another look at the procedures and the administration of the program. So your examples are, I am afraid, typical of what has happened across the country.

Mr. **SKELTON**. Well, it does cause people concern if you look at it through their eyes. Their doctors, cardiologists say you cannot work. If you do, you are liable to kill yourself and even get to the cemetery, as some of the testimony says.

Chairman **PICKLE**. What do you mean in your testimony when you said that a social security district manager in your district had given you a memorandum——

Mr. **SKELTON**. It is a memorandum that he sent to his superior.

Chairman **PICKLE**. It was a memorandum in which he accused the Social Security Administration of ignoring the opinion of an eminent cardiologist in its fervor to accomplish its mission. What do you think or what does he think——

Mr. **SKELTON**. I do not know what he thinks. We only have what he has here. We can only suppose what that mission is. Evidently, it seems like the mission is to cut down the number of people receiving these benefits, which certainly is not right.

If someone is truly disabled they should be able to receive the benefits available under the social security law that has been passed. There is evidently, according to his words, some fervor to change this. There are two problems. That is, one, the problem of cutting off the benefits in light of strong medical evidence to the contrary. The second problem is the appellate process, the huge backlog. Someone is denied continuation or their benefits are stopped and then they have, because of the large backlog it will be a long time before their appeal is heard.

Now what is interesting is the large number of reversals once that appeal is heard. In other words, cutting it off at the first level in many, many instances is just wrong, according to the appellate process, but they are penalized during this interim between the cutting off date until they are finally heard.

Chairman **PICKLE**. Mr. Gradison.

Mr. **GRADISON**. Mr. Chairman, I just would like to thank our colleague for appearing and particularly for summarizing for us the cases which have gone through his office. I think the experience which you had is not unlike the experience we have had with a number of these cases, and I appreciate your taking the time to share this information with the subcommittee. It will certainly be helpful to us.

Mr. **SKELTON**. Thank you. I just want to stress that these people feel helpless and I would hate to see an attempt to balance our Federal budget on the backs of these people, who are truly in need. This is a situation, from all of the evidence that I have been able to see, Mr. Gradison, these people are truly in need and there is, in the words of this district manager, a wholesale mishandling of these cases.

Chairman **PICKLE**. We are pleased to have Mr. Conable with us this morning. Would you care to pose any questions?

Mr. **CONABLE**. I do not think Mr. Skelton needs to confirm the conditions that I found to some degree in my district. That is one of the reasons why I thought this type of oversight is appropriate. This committee itself has been concerned about the growth of disability and the exercise of an appropriate congressional oversight.

We have been trying to find ways of preventing unreasonable growth of the number of people that are on disability, the assumption being that some are not disabled. However, whether it is zeal or whatever it is, the pressure that is being exerted within the social security system to reduce the number of people on disability in some cases has evidently had capricious results, with people being lopped off without adequate medical analysis of their condition and sometimes at considerable hardship for which the procedural remedy is a very long time in coming, thus creating unnecessary hardship.

I think we are going to have to continue to struggle with this, Mr. Chairman, with the advice of people like our colleague about what is happening in the district because Congress cannot ignore the results of the pressures it is bound to exert through fiscal restraint on the system which has to be administered still in a humane way.

We will continue to do the best we can on this and I want to congratulate the chairman on his interest in trying further to define an appropriate balance between humane generosity and, in some cases, an opportunity for people who are not necessarily disabled to benefit at the expense of those who are more appropriately the beneficiaries of the system.

Thank you, Mr. Chairman. Thank you for coming in and confirming the conditions in your area.

Chairman PICKLE. Well, we thank you, Mr. Conable. Your opinion and your cooperation in this area and in the social security program both—we very much appreciate it. We thank you again.

We thank you, Mr. Skelton. Your testimony is very helpful.

Mr. SKELTON. Thank you.

Chairman PICKLE. I would ask Mr. Michael Lomax if he will take a seat at the witness table. Is Mr. Lomax here? It is a panel—Mr. Lomax, and then we have Mr. Joe Galotti, and Mr. James Allen Cox, Jr. If you will take your seats Mr. Lomax, Mr. Galotti, and Mr. Cox.

Mr. Lomax is president of the National Association of Disability Examiners and Mr. Galotti is the associate commissioner of the Connecticut Division of Vocational Rehabilitation. He represents the Council of State Administrators of Vocational Rehabilitation.

Mr. Cox is the executive director of the National Association of Rehabilitation Facilities. We are pleased first to receive testimony from Mr. Michael Lomax.

STATEMENT OF MICHAEL LOMAX, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Mr. LOMAX. Thank you, Mr. Chairman. I have provided a report that I would like included.

Chairman PICKLE. I believe we had one other gentlemen at the witness table here with Mr. Galotti. Would you identify yourself?

Mr. GALOTTI. This is Mr. Richard Phelan of the Texas Rehabilitation Commission. He is here as a technician.

Chairman PICKLE. Mr. Phelan, we are particularly glad to have you here. I know your testimony will be very helpful.

Now, Mr. Lomax, would you continue?

Mr. LOMAX. Thank you, Mr. Chairman. I have an entire report that I would like included in the record and I would like to draw information and raise points in the amendments as you have outlined and we would like to comment on those this morning.

Chairman **Pickle**. The entire statement will be made part of the record. Now are you going to follow item 1?

Mr. **Lomax**. Correct.

Our national association has been on record since November 1981 in support of the adjustments proposed in the bill. Many people were put on the rolls, never intending to be reviewed. The recent changes have convinced claimants and beneficiaries that the program is being "tightened up."

Claimants were put on the rolls in periods of time when State agencies were under severe pressure to move cases. Also, the rules and regulations have changed. Claimants put on the rolls with one standard are now being reviewed and removed from the rolls with a different standard. In many cases there has been no change in the medical condition.

The amendments do provide the additional 4 months of benefits needed to make this transition from claimant to potential taxpayer.

The provisions of offering vocational rehabilitation services for medically terminated CDI's for evaluation and placement is excellent in theory. Vocational rehabilitation referrals from State agencies have of late been discouraged. There is no reason to believe that this will now change. The function will be better housed in agencies who have a history of providing these types of services in the past.

The current appeals process from the title II claim has led to the ever-increasing hardship on the claimant. This process can take months through the recon period and through the appeals period. A claimant can be without a check for up to 7 months or longer awaiting a decision from the ALJ. The extra months of payment during the appeal process will give the claimant a chance to adjust and make plans for returning the overpayments.

2. In provisions to increase roll of reconsideration process. The claims going through the State agency has produced in effect a double review of the claim in a short time frame of 60 days. Claimants in desperation immediately jump to filing a reconsideration in that short period of time. There probably will not be a change in the claimant's condition nor a chance to determine if there is deterioration of that condition.

The State agency can provide a more substantive decision on a claim involving the issue of duration of the impairment and the deterioration of that condition. This will not help the claimant who files a reconsideration on the same day they get their initial notice, though.

Closing the record at the reconsideration can have a definite impact on the decision now rendered at the reconsideration level. Examiners are faced with the claimant who will not submit any new evidence or allegations but just wants a decision to speed the appeals process.

In some cases the claimant has been told by the attorney not to submit additional evidence or to go to an examination that would slow the appeals. Closing the record at the recon will close a loophole that attorneys now exploit. Closing the record will force the

ALJ to make a decision on the evidence in the file and this would prevent the appeal of the case from dragging on for several months while new evidence is being sought.

Additional time at the reconsideration level will result in the State agencies having to get further additional examinations which will increase the medical cost per case. It has been suggested that it is to the benefit of the attorney to carry out the appeal as long as possible in order to reap the maximum in overpayments.

The same problem may also occur now at the reconsideration level. The bill is to give a face-to-face decision before determination of disability benefits and we agree that the claimant should be accorded a face-to-face hearing and the opportunity to submit additional statements before termination of benefits.

State agencies examined this several years ago under the RIS or what was called the recon interview study program. Results proved this interview to be very time consuming and required the use of additional manyears, budget funds and clerical support. Congress must be ready to include additional funding and staff in order to complete the face-to-face hearing objectives.

Under the provisions to provide more uniformity of decisionmaking, one of the most confusing processes to someone working in the disability program are the different sets of rules and regulations. Many examiners become frustrated working disability claims knowing that the final outcome of the decision is beyond their control, when ALJ's reverse 60 percent of their decisions.

There is definitely something wrong with the process of adjudicating disability claims when a claim is denied at the initial level and reconsideration level, only later to find out that the claim was reversed by the ALJ at the appeal level on the "rule of substantial evidence". It is frustrating to examiners conducting CDI's, knowing no matter how hard they try to document a claim or prepare factual documentation their decision stands an excellent chance of being reversed.

The central office review finds a 95 percent accuracy rate for a State, but an ALJ in the same area finds a 70 percent reversal rate. This raises a serious question about the ALJ process in its entirety and these are crippling the disability program.

Louis Hays indicated a total of 66 judges with a reversal rate higher than 70 when being reviewed. The Bellmon amendment indicated 22 percent were reversed or remanded back to the ALJ by the Appeals Council analyst, 22 percent of the claims at this level is a significant number. An error rate of this gravity would put a State agency in "substantial failure."

Standardization of the rules and regulations used by the State agencies and ALJ's is a definite step in the right direction. The review of the State agency decision and the review of the ALJ decision should be performed under the direction of the central office. Our motion review of ALJ decisions to 35 percent is better than nothing, but entirely too low in view of the high 22 percent remand back to the ALJ.

The ALJ review process over the next 5 years probably should be maintained at 100 percent to insure that they have a clear understanding of the rules and regulations, similar to what SSA's 100 percent review of State agency claims prior to the review of the SSA program.

The association in 1974 introduced the concept of social security disability court. The establishment of this court is needed to reduce the backlog of the cases in the Federal court system at the present time. We must ask from where will these judges come. Will they come from the already appointed administrative law judges? If so, we have saved nothing! The social security court should have a government representative to insure that the rules and regulations are followed.

Disability evaluation, on the other hand, is one of the hardest concepts to introduce to a physician because of the complex physical and mental criteria introduced. With the introduction of courses in the medical universities we can only begin to introduce the physician to the objective evidence needed in the disability decision.

We need to also focus on the physician now in practice as well. The Advisory Council needs to establish continuing education credits for physicians which they must complete in order to do consultative work in the State agency.

The Advisory Council function should not stop with the physician. It should include the heart of the disability program—the examiner. In many instances the examiner is the one ordering the consultative examinations, speaking with a physician on the phone to clarify issues and to gather information from the claimant about their medical condition.

More money needs to be placed in the area of training for the examiner. The national association is the only organization that offers additional training in this field. We wholeheartedly encourage additional funding for training and the possibility of Federal certification of disability examiners.

On the provision to provide more accountability in the consultative examinations it is and has or was the responsibility of the DDS to further contract out with a third party. The payment of fees for providing that report was also left to the DDS. Many States' accounting systems have been set up to handle the routine medical payment process and no additional reporting was required of these State agencies in the past.

What H.R. 5700 proposes to do is set up a fiscal agent to handle the payment of bills received and the contracting out of medical exams. The control is being shifted to the agent when the State was never asked to keep the records on the medical providers. It seems a drastic change in the accounting practice of the consultative exam, when a State was never asked to provide this information in the first place.

Under prevailing fees, some physicians will not work with a State agency because of low fees being paid by that agency. Prevailing fees will interest more physicians in doing exams. However, there are some States that are able to pay more than the prevailing rate at the present time.

The bill should provide some alternatives. There should be a minimum established, for example, the prevailing fee rate, a current fee schedule now in practice in that State, and a ceiling established in that particular area.

Under miscellaneous provisions, the aspects of other provisions is the deregulation of attorneys fees. It is our feeling that the claimant should be the one to contract to provide payment of the attorney for the services that they have rendered.

Mr. Chairman, in conclusion, I have what we recommend are changes in H.R. 5700, which I have outlined on page 8, which include 100 percent review of the on-motion of ALJ allowances; the review process being done centrally, reviewing both State agency and ALJ decisions in one location; providing additional funding to the State for the face-to-face hearing of determination and the extension of the reconsideration period; include the disability examiner, both at the State level and at the Federal level, in continuing education; adding the Government representative at the Social Security Court level or below; elimination of the single carrier from the bill; and establishment of a minimum fee schedule.

Mr. Chairman, thank you.

[The prepared statement follows:]

STATEMENT OF MICHAEL LOMAX, PRESIDENT, NATIONAL ASSOCIATION OF DISABILITY EXAMINERS

Mr. Chairman, thank you for allowing the National Association of Disability Examiners to present our views on H.R. 5700 Disability Amendments of 1982.

There are several interesting points raised in the amendments as you have outlined in the bill and press releases. The National Association would like to comment on them and make recommendations on several.

1. PROVISIONS TO PROVIDE ADJUSTMENT IN DISABILITY TERMINATION (CDI) PROCESS

The temporary provisions in the bill to provide adjustment to terminated claimants in addition to helping claimants will also help state agencies public relations. Our National Association has been on record since November 1981 in support of the adjustments proposed in the bill. Many people were put on the roles never intending to be reviewed by a government agency. The advent of the recent changes made had convinced claimants and beneficiaries that the program is being "tightened up". This is true in that claimants were put on the roles in periods of time (1974 the beginning of SSI) when state agencies were under severe pressure to move cases. Also the rules and regulations (listing of Impairments) have changed. Claimants were put on the roles with one standard and are now being removed from the roles with a different standard. In many cases there has been no change in their medical condition. These claimants have come to rely on the social security payment to meet every daily living expenses. To terminate their benefits after relying on them so heavily is unjust. The amendments to provide an additional four months of benefits is needed to make the transition from claimant to potential taxpayer.

There is another issue that is linked very closely with termination of benefits. This is retroactive cessation. Cessation in the past (more than two months) presents a definite hardship on the claimant to pay back funds from that time. This bill addresses the problem and waves the overpayment in medically terminated cases. The bill also provides that this will be a temporary measure only through calendar year 1984.

The provision of offering vocational rehabilitation services for medically terminated CDI'S for job evaluation and placement is excellent in theory. Vocational rehabilitation referrals from state agencies have of late been discouraged. There is no reason to believe that this will now change. This function would be better housed in agencies who have a history of providing these types of services.

If the claimant is dissatisfied with the CDI decision, the claimant may file for a reconsideration and benefits will continue during this appeal period.

The current nature of the appeals process for title II claims has led to the every increasing hardship on the claimants awaiting a decision as to the outcome of their disability claim. This process can take months through the recon period and then the appeals period. A claimant can be without a check for up to 7 months or longer awaiting a decision from the ALJ. For claimants who are erroneously ceased, this will keep them from suffering a total financial hardship. The extra months of payment during the appeal will give the claimant a chance to adjust and make plans for returning the overpayments.

2. PROVISIONS TO INCREASE ROLE OF RECONSIDERATION PROCESS

The claim flow through the state agency has produced in affect a double review of the claim in a short time frame of sixty days. From the time the claimant gets their initial denial notice, they now have sixty days in which to ask for a reconsideration. The claimants in desperation immediately jump to filing a reconsideration. In that short period of time, there probably will not be a change in the claimants condition, nor a chance to determine if there is a deterioration of the condition.

With the lengthening of the reconsideration process from the sixty days to six months the state agency will receive requests at a longer duration from the initial decision. The state agency can provide a more substantive decision on the claim involving the issue of duration of the impairment and the deterioration of the condition. This will not help the claimant who files a reconsideration the same day they get their initial notice, but is intended to help the claimant who waits and considers the possible outcome of their impairment.

The closing of the record at reconsideration can have a definite impact on the decision now rendered at the reconsideration level. Many times examiners are faced with the claimant who will not submit any new evidence or allegations but just wants a decision to speed the appeals process. In some cases the claimant has been told by their attorney not to submit additional evidence or go to an examination that would slow their appeals. Closing the record at the reconsideration will close this loophole that attorneys now exploit. Closing the record at the reconsideration will force the ALJ to make a decision on the evidence in file at the time of the hearing. This should prevent the appeal of the case from dragging on for several months while new evidence is being sought. This evidence will have to be submitted now at the reconsideration level. The additional time at the reconsideration level will result in the state agencies having to get additional examinations which will increase the medical costs per case. It has been suggested that it is to the benefit of the attorney to carry out the appeal as long as possible in order to reap the maximum in overpayments due the claimant. The same problem may also now occur at the reconsideration level.

The face to face hearing contemplated in the bill is to give the claimant a chance for a face to face decision before the termination of the disability benefits. We agree the claimant should be afforded the face to face hearing and the opportunity to submit additional statements before the termination of benefits.

State agencies examined this several years ago under the RIS (recon interview study) program. The results proved this interview to be very time consuming and required the use of additional man years, budget funds, clerical support, etc. to carry out. Congress must be ready to include additional funding and staff in order to complete the face to face hearing objective.

3. PROVISIONS TO PROVIDE MORE UNIFORMITY OF DECISIONMAKING

One of the most confusing processes to someone working in the disability program are the different sets of rules and regulations under which claims are adjudicated and then appealed. Many examiners become frustrated working disability claims knowing the final outcome of their decision is beyond their control when ALJ's reverse 60 percent of their decisions. There is definitely something wrong with the process of adjudicating disability claims when a claim is denied at the initial level and reconsideration level only later to find out the claim was reversed by the ALJ at the appeal level on "the rule of substantial evidence." This same claim is then denied by the administration, and most likely ceased upon review by the S/A only to be revised on appeal.

It is frustrating to examiners conducting CDI's knowing no matter how hard they try to document a claim or prepare factual documentation; their decision stands an excellent chance of being reversed.

Review of state agency claims by the central and regional offices shows the states within the guides established for them. However, the reversals of state agencies decisions by the ALJ's show a different interpretation. When central office review finds a 95 percent accuracy rate for a state but an ALJ in the same area find a 70 percent reversal rate. This raises a serious question about ALJ decisions.

Many of the decisions are based on differences in interpretation of laws and regulations. These differences are crippling the disability program.

Louis Hays, Associate Commissioner, Office of Hearings and Appeals, recently at a meeting of the DDS subcommittee of CSAVR indicated a total of 66 judges with a reversal rate higher than 70 percent were being reviewed. The Bellmon amendment indicated 22 percent were reversed or remanded back to the ALJ by the Appeals Council Analysist. 22 percent of the claims at this level is a significant number. An error rare of this gravity would put a state agency in "substantial failure."

The need for uniform rules and regulation at all levels needs to be stressed. Standardization of the rules and regulations used by the state agencies and ALJ's is a definite step in the right direction. However, who will monitor these ALJ's to see if the rules and regulations are being followed. The review of state agency decisions and the review of ALJ decisions should be performed under the direction of the central office. Then and only then can the congress determine if the rules and regulations are being applied in a standard way.

Increasing or formally establishing the Own motion review of ALJ decisions to 35 percent is better than nothing but entirely too low in view of the high 22 percent remand back to the ALJ's. The ALJ review process over the next five years should be maintained at 100 percent to insure they have clear understanding of the rules and regulation similiar to SSA's 100 percent review of state agencies claims prior to the addition of the SSI program.

The introduction of the Social Security Court is not a new concept to our association. The association in 1974 introduced the concept of a social security disability court. The establishment of this court is needed to reduce the backlog of cases in the federal court systems at present. The court which will develop a level of expertise in this field will only hear matters pertaining to social security claims. The claims should move faster through the courts and the claimant will not have to wait as long for a decision.

The appointment of the judges by the President pose no problem, but we must ask from where will these judges come. Will they come from the already appointed Administrative Law Judges? If so, we have saved nothing. To insure the court system is set up to do what it is intended to do, the judges should also undergo training in social security rules and regulations. Further, the social security court should have a government representative to insure the rules and regulations are followed. The idea of the government representative is a good one with or without a Social Security Court.

Disability evaluation is one of the hardest concepts to introduce to a physician because of the complex physical and mental criteria introduced.

Physicians in the medical profession are used to treating the patient for the specific complaints or the routine health care maintanance visits that include height, weight and blood pressure checks. Most physicians treatement records only include the basic necessities for the treatment of the patient and not the detailed objective findings required for a disability decision. With the introduction of courses in the medical universities, we can then only begin to introduce the physician to the specific objective evidence needed for disability decisions. At the present time, the most informative physicians are right out of medical school. There history and physical are detailed and usually complete.

They have just completed there schooling which required this detailed work. Physicians trained in the evaluation concepts more than likely will be able to give the needed information on first request or after a follow-up phone call.

Naturally, we can offer these courses in the classroom for physicians who have not yet completed their study. However, we need to also focus on the physician now in practice. The advisory council needs to establish continuing education credits for the physicians which they must complete in order to do consultative work for the state agency. We discussed the problems of the volume provider in previous testimony. Continuing educational funding for physicians could improve the reporting and examination of the claimant.

The advisory council function should not stop with just physicians but should include the heart of the disability program, the Examiner. If the money is spent to educate the physician there should be a sizeable sum used to further educate the disability examiner. In many instances the examiner is the one ordering the consultative examination, speaking with the physician on the phone to clarify issues, gathering information from the claimant about there medical condition. These factors are important in the development and adjudication of the claim.

The National Association offers annual training conferences for people in the disability field. However, because of state budgets, a very limited number of examiners can attend a training conference. More money needs to be placed in the area of training for the examiner. The National Association is the only organization that offers additional training in this field. We wholeheartedly encourage additional funding for training and the possibility of federal certification of disability examiners.

4. PROVISIONS TO PROVIDE MORE ACCOUNTABILITY IN CONSULTATIVE EXAMINATIONS

Throughout the years the state agency has had the responsibility to gather medical and vocational information for the disability claim. Also, it is the responsibility of the DDS to further contract out with a third party to provide an independent evaluation of the claimants condition. The payment of the fees for providing that report was also left up to the DDS. This has usually been tied in with most state administative services departments who will issue the warrants for the vendors involved. This service is usually provided to the DDS for a charge or included in the indirect charges assessed against a DDS. Many states accounting systems have been set up to handle the routine medical payment process. No additional reporting was required for the state agency other than the medical obligations report and encumberances reports. With the advent of the volume provider and the cost involved, some states could not readily put their hands on a dollar amount that was paid.

What H.R. 5700 proposes to do is set up a fiscal agent to handle the payment of bills received from the contracting out of medical exams. This will create a fiscal agent to report to the SSA on the volume provider. The control is being shifted to the agent when the states were never asked to keep records on the medical providers. It seems a drastic change in the accounting practice of the Consultative exam process when the states were never asked to provide this information in the first place.

Who pays for the Medical evidence of record? Does the state still do this? A physician will then be asked to send one bill to the fiscal agent and another to the state DDS for processing. Who will get the call for the delayed payment? Who will stop reporting to the state agency when the fiscal agent falls behind in the payment practice. Who will monitor the bills to insure what was requested by the examiner was really done? Who is responsible for duplicate bills?

Although some states are behind in the payment of the medical records and payment of consultative exams, the state agency in dealing with the vendor can usually explain the process and track down the problem for the vendor. Can we with the fiscal agent who is handling payments for all the states?

PREVAILING FEES

The prevailing fees concept is important for the continuation of the program in some areas. Some physicians will not work for the state agency because of the low fees being paid by the state agency. The state agency in turn must rely on physicians who will provide services for the fees allotted by the state.

The prevailing fees will interest more physicians in doing exams for the state agency. However, there are some states that are able to pay more than the prevailing rate in their particular area. The bill should provide some alternatives to the coverage of the fee schedule. There should be a minimum established (prevailing fees), current fee schedule now in practice, and a ceiling established (usual and customary fees).

5. PROVISIONS TO PROVIDE MORE RECENT ATTACHMENT TO WORKFORCE AS A REQUIREMENT FOR INSURED STATUS

The introduction of the additional requirement poses no problem to the state agency. With the additional requirement it will indicate an onset of disability in the last four years. It will provide for the securing of the records from hospitals, clinics and physicians on a more current basis. The question of the two out of the last six years will create some difficulties for the social security offices in figuring the insured status for the claim as the posting of the records in Baltimore is many years behind.

6. MISCELLANEOUS PROVISIONS

The most important aspect of the other provisions is the deregulation of the attorney's fees for the disability claimant. It is our feeling the claimant should contract to provide payment to the attorney for services rendered. It is speculation with the volume attorney's that we can see a definite problem occurring with unusual high pricing of attorney's fees and the payment of fees.

NATIONAL ASSOCIATION OF DISABILITY EXAMINERS RECOMMENDATIONS FOR CHANGES IN H.R. 5700

1. 100 percent of own-motion review of ALJ allowances.
2. The review process be done centrally reviewing both state agency and ALJ decisions.
3. Provide additional funding to the state for the face to face hearing at termination and the extension of the reconsideration period.
4. Include the Disability Examiner both at the state level and Federal level in continuing education.
5. Adding the government representative at the Social Security Court level or below.
6. Elimination of the single carrier from the bill and give additional authority to control the costs per vendor to the state.
7. Establishment of a minimum fee schedule.

Chairman PICKLE. Mr. Lomax, you have certainly given us a broad statement. We will defer questions until we hear all the witnesses. Is that agreeable?

Mr. GRADISON. Yes.

Chairman PICKLE. The next witness will be Mr. Joe Galotti, the associate commissioner.

Mr. Galotti.

STATEMENT OF JOSEPH GALOTTI, DIRECTOR, DIVISION OF VOCATIONAL REHABILITATION, STATE OF CONNECTICUT, AND CHAIRMAN, DISABILITY DETERMINATIONS SUBCOMMITTEE, COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION, ACCOMPANIED BY RICHARD H. PHELAN, PROGRAM SPECIALIST, TEXAS REHABILITATION COMMISSION

Mr. GALOTTI. Mr. Chairman, my name is Joe Galotti and I appear before the subcommittee as the director of the Connecticut Division of Vocational Rehabilitation and as chairman of the Disability Determinations Subcommittee of the Council of State Administrators of Vocational Rehabilitation.

The chairman of the Council's Standing Committee on Social Security Relationships, Max Arrell, is unable to be here but as I indicated before, he has sent a member of his staff, Mr. Phelan of the Texas Rehabilitation Commission, to assist in the testimony.

Chairman PICKLE. Glad to have you, Mr. Phelan.

Mr. GALOTTI. The Council of State Administrators of Vocational Rehabilitation is an association composed of the chief administrators of all State agencies providing rehabilitation services to physically and mentally disabled persons in the States. The council is a forum for State rehabilitation directors to study, deliberate and to act upon matters pertaining to the successful rehabilitation of persons with disabilities.

The council's Standing Committee on Social Security Relationships is charged with studying matters relating to the beneficiary rehabilitation program and the SSI rehabilitation program. The council's Standing Subcommittee on Disability Determination Services is charged with studying matters affecting the disability determination process.

Mr. Chairman, the council appears before this subcommittee today to present its views and concerns regarding H.R. 5700. The council's testimony will focus on section 17, which pertains to the social security vocational rehabilitation program.

Prior to October 1, 1981, State vocational rehabilitation agencies received up-front moneys from the trust funds and general revenues to provide VR services to eligible SSDI and SSI beneficiaries. Despite the demonstrated cost-effectiveness of these programs, funding was cut from approximately $124 million in fiscal year 1981 to an estimated $3 million in fiscal year 1982.

This dramatic cut in funding of over 97 percent was coupled with a provision in the Omnibus Reconciliation Act of 1981 which created a situation in which State vocational rehabilitation agencies are reimbursed for the cost of services after a client engages in substantial gainful activity for 9 months.

Under the present law States may have to wait years before reimbursement funds are available. The Council of State Administrators of Vocational Rehabilitation is pleased to note that the first major provision of section 17 of H.R. 5700 would replace this reimbursement program with an expanded advance funding program. We believe that this proposal, if enacted, would help to make vocational rehabilitation services more readily available to disabled persons and for this reason the council is generally in support of section 17.

There are few provisions in this section, however, which the council would urge the subcommittee to modify. With regard to this first major provision to replace the reimbursement program with advance funding program, the council recommends that the Subcommittee on Social Security consider making the Commissioner of the Rehabilitation Services Administration the administrator of this program in place of the Commissioner of the Social Security Administration.

We recommend this for two reasons. One, vocational rehabilitation is the area of expertise of the Rehabilitation Services Administration. Two, the program would represent a larger portion of the RSA budget and thus would be given a higher priority in the RSA than it might have at the SSA.

The second major position would establish a new program of funding rehabilitation services to former beneficiaries whose benefits were terminated due to medical recovery. This program would be funded for 2 years and would be limited to vocational evaluation and job placement services.

With regard to the 2-year funding, the council recommends that the subcommittee require the Rehabilitation Services Administration to provide a program status report to the U.S. Congress in July of 1984. Upon receipt of this report the Congress could consider whether to extend, modify or terminate the program.

The council also recommends that the funds not used in the first year of the program be available for use if needed in the following year.

With regard to limiting services to vocational evaluation and job placement, the council recommends that the subcommittee expand this program to include whatever vocational rehabilitation services may be reasonable and necessary to return the former beneficiary to suitable employment.

The third major provision of section 17 would repeal the provision of the Disability Amendments of 1980 which allows for the continuation of benefits to rehabilitation clients. Beneficiaries whose benefits are terminated frequently cannot afford to participate in vocational rehabilitation services. The council recommends that the subcommittee consider retaining this provision of the Disability Amendments of 1980.

The fourth major provision of section 17 would mandate that the Social Security Administration utilize its authority to establish at least 10 experimental and demonstration projects in at least five States. The council supports this provision and encourages the Social Security Administration to include in these projects the participation of State vocational rehabilitation agencies and the Rehabilitation Services Administration.

Finally, most of the provisions of section 17 apply only to social security disability insurance beneficiaries. The council strongly recommends that the U.S. Congress add to the bill parallel provisions for title XVI supplemental security income recipients.

Mr. Chairman, the council is also pleased to note that section 11 of H.R. 5700 would create an advisory council on the medical aspects of disability. The CSAVR is in agreement with the language in the bill which would create this advisory council and we stand ready to recommend, as stipulated in the bill, the appointment of a suitable representative from the CSAVR to serve on the advisory council.

In conclusion, the Council of State Administrators of Vocational Rehabilitation is generally in agreement with section 17 of the proposed Disability Amendments of 1982. The CSAVR would like to state its appreciation for and its agreement with statements made on the floor of the U.S. House of Representatives by the chairman of this subcommittee in clarifying the advance funding provisions of the beneficiary program.

Mr. Chairman, the Council of State Administrators of Vocational Rehabilitation appreciates being provided with this opportunity to comment on H.R. 5700. Also, at a later date CSAVR will submit written testimony on the aspects of H.R. 5700 which focus on disability determinations.

Thank you, Mr. Chairman.

[Two prepared statements follow:]

STATEMENT OF THE COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

The Council of State Administrators of Vocational Rehabilitation (CSAVR) is an association composed of the chief administrators of all the state agencies providing rehabilitation services to physically and mentally disabled persons in the states, the District of Columbia, and the territories. Founded in 1940 to furnish state input into the State-Federal Vocational Rehabilitation Program, the Council has, since then, served as a quasi-official advisor to its Federal partner, the Rehabilitation Services Administration, and has provided a forum for State Rehabilitation Directors to study, deliberate and act upon matters pertaining to the successful rehabilitation of persons with disabilities.

Through its Committee on Social Security Relationships, and the Disability Determination Services Subcommittee, the Council interacts with the Social Security Administration (SSA), the Rehabilitation Services Administration (RSA), and other groups with respect to issues affecting the Disability Insurance Program (Title II), the Supplemental Security Income Program (Title XVI), and the Beneficiary and SSI Rehabilitation Programs. The Social Security Relationships Committee's membership consists of State Rehabilitation Directors, and SSDI/SSI Coordinators for State Rehabilitation Agencies. There are ten State Disability Determination Services Administrators on the DDS Subcommittee, one from each of the ten Federal regions, who serve as the liaison between the CSAVR Committee and other DDS Administators in their regions. The full Committee is charged with matters relating to rehabilitation, and the DDS Subcommittee is charged with matters affecting the disability determination process.

Mr. Chairman, the Council appears before this Subcommittee today to present its views and concerns regarding H.R. 5700, the proposed "Disability Amendments of 1982." The Council's testimony will focus primarily on Section 17 of the proposed bill, which pertains to the SSA/Rehabilitation Programs.

Prior to October 1, 1981, State Rehabilitation Agencies received "up-front" monies from the SSDI Trust Funds and the General Revenues for the provision of services to eligible SSDI and SSI beneficiaries. (Under the previous beneficiary programs, funds were made available, on a regular, quarterly basis. by the Administration (SSDI Trust Funds) and by the Congress (General Revenue Funds) directly to the State Rehabilitation Agencies for the provision of these services.) Since these beneficiaries, especially SSDI beneficiaries, are severely disabled, it is more difficult, costly, and time-consuming to rehabilitate these individuals.

Despite the demonstrated cost-effectiveness of these programs, the funding was cut from approximately $124 million in fiscal year 1981, to an estimated $3 million in fiscal year 1982. This dramatic cut in funding—of over 97 percent—was coupled with a provision, approved as part of the Omnibus Reconciliation Act of 1981, that has created a situation where State Rehabilitation Agencies are being reimbursed by the Social Security Administration for only the costs of rehabilitation services resulting in the client's participation in Substantial Gainful activity for nine months.

Under the present law, states may have to wait years before reimbursement funds are made available. In addition to the period of nine months of substantial gainful activity, there are also the many months, even years, which are required to successfully rehabilitate a severely disabled person. During this time, the States incur, and will continue to incur, substantial expenses for services. Fiscal planning is being severely disrupted with respect to these reimbursed funds, since State Agency fiscal planners are unable to ascertain when or in what amount funds will be received. Also, under the current law, there will be a sharp decline in the number of eligible persons with disabilities who will receive rehabilitation services.

BENEFICIARY REHABILITATION PROGRAM

The Council of State Administrators of Vocational Rehabilitation is pleased to note that the first major provision of Section 17, of H.R. 5700, would replace the "reimbursement" program with an expanded "advance" funding program for the provision of rehabilitation services under this beneficiary program. We believe that this proposal, if enacted, would help to make vocational rehabilitation services more readily available to disabled persons, and for this reason, the CSAVR is generally in support of Section 17, of H.R. 5700.

There are a few provisions in this Section of the bill, however, which the Council would urge the Subcommittee to modify.

With regard to this first major provision of the Section—to replace the reimbursement program with an advanced funding program—the Council recommends that the Subcommittee on Social Security consider making the Commissioner of the Rehabilitation Services Administration the Administrator of this program, in place of the Commissioner of Social Security. We recommend this for two reasons.

1. This is a program of vocational rehabilitation services, an area in which the Rehabilitation Services Administration has far more expertise than does the Social Security Administration.

2. Since this program would represent a minuscule portion of the Social Security Administration budget, it is reasonable to expect that it would not be given a high priority in the SSA organization. Conversely, it would represent a much larger portion of the Rehabilitation Services Administration budget, and would be given a higher priority within the RSA.

REHABILITATION SERVICES TO FORMER BENEFICIARIES

The second major provision of Section 17, would establish a new program for funding of Vocational Rehabilitation Services for beneficiaries whose benefits are terminated due to medical recovery. This program would be funded for each of two years, and would be limited to vocational evaluation and job placement services. We recommend that the subcommittee consider modifying these two aspects of the program.

Since it is reasonable to expect that beneficiaries will continue to have their benefits terminated in the years after fiscal year 1984, and that Vocational Rehabilitation Services will be needed to return them to work, we recommend that the subcommittee require the Rehabilitation Services administration to provide a program status report to the U.S. Congress in July 1984. This would allow the Congress to consider at that time whether to extend, modify, or terminate the program based on program results. Further, we recommend that the funds not used in the first year of the program be available for use, if needed, in the following year.

Limiting this program of Vocational Rehabilitation Services to Vocational Evaluation and Job Placement may at first glance seem to be consistent with the concept that beneficiaries who "medically recover" are no longer "disabled." Being no longer "disabled" under the Social Security Act, however, does not mean that the former beneficiary is readily employable. It merely means that the former beneficiary's medical condition does not preclude the performance of some type of work which is available somewhere in the national economy.

The former beneficiary may need vocational training to obtain one of the jobs available in the city or town in which he lives. There may be additional medical services that be may need to enable him to return to the type of work he has performed in the past. Vocational Counseling undoubtedly will be needed to return him to suitable employment. We strongly recommend that the Subcommittee consider expanding this program to include whatever Vocational Rehabilitation Services may be reasonable and necessary to return the former beneficiary to suitable employment.

CONTINUATION OF BENEFITS TO REHABILITATION CLIENTS

The third major provision of Section 17 would repeal the provision of the Disability Amendments on 1980, Public Law 96-265, which allows the Social Security Administration to continue to pay benefits to beneficiaries who have medically recovered; if the beneficiaries are participating in a Vocational Rehabilitation program which is expected to increase the likelihood of permanent removal from the disability benefit rolls. The Council of State Administrators of Vocational Rehabilitation supported this provision when it was introduced and enacted in 1980, and we oppose its repeal at this time, for essentially the same reason.

Beneficiaries, whose benefits are terminated, frequently cannot afford to participate in Vocational Rehabilitation Services. If they do not have an income with which to pay for the basic living expenses of food and shelter, they cannot afford to be in vocational training programs which would prepare them for suitable employment, and may be forced to accept jobs which are likely to aggravate their medical conditions and return them to the disability benefit rolls.

We recommend that the Subcommittee consider retaining this provision of the Disability Amendments of 1980.

EXPERIMENTAL AND DEMONSTRATION PROJECTS

The fourth major provision of Section 17 would mandate that the Social Security Administration utilize its authority under the Disability Amendments of 1980 to establish at least ten (10) experimental and demonstration projects in at least five (5) states. The Council of State Administrators of Vocational Rehabilitation supports this provision, and encourages the Social Security Administration to include in these projects the participation of the State Vocational Rehabilitation Agencies and the Rehabilitation Services Administration.

NEED TO REVISE SSI/REHABILITATION PROGRAM

Finally, most of the provisions of Section 17, H.R. 5700, the proposed "Disability Amendments of 1982," apply only to Title II (SSDI) beneficiaries. The Council of State Administrators of Vocational Rehabilitation recommends that the U.S. Congress add to the bill parallel provisions for Title XVI (SSI) recipients.

SECTION 11; ADVISORY COUNCIL ON THE MEDICAL ASPECTS OF DISABILITY

Section 11(b)(1) of H.R. 5700, would create an Advisory Council on the Medical Aspects of Disability. The Council of State Administrators of Vocational Rehabilitation would like, at this time, to state that we are in agreement with the language in H.R. 5700 which would create this Council, and that the CSAVR stands ready to recommend the appointment of a suitable representative from the CSAVR to serve on the Council, as is stipulated in the bill.

CONCLUSION

As stated previously, the Council of State Administrators of Vocational Rehabilitation is generally in agreement with Section 17, of H.R. 5700, the "Disability Amendments of 1982." The CSAVR would also like to state its appreciation for and agreement with statements made on the floor of the U.S. House of Representatives by the Chairman, in clarifying the "advance" funding provisions of the beneficiary programs. The CSVAR firmly believes that advance payments to the states are vital if the Beneficiary Rehabilitation Programs are to continue to provide cost-effective rehabilitation services to persons with mental and physical disabilities. Furthermore, if the Beneficiary Rehabilitation Programs are to achieve the dual goals of providing necessary rehabilitation services to eligible beneficiaries, and to achieve a savings to the Trust Fund, the CSAVR recommends that the providers of services under this program be recognized for the cost of all rehabilitation services provided beneficiaries that result in a direct savings to the Trust Fund, regardless of a beneficiary's inability to engage in SGA for the required time period.

The Council of State Administrators of Vocational Rehabilitation appreciates the opportunity to comment on this bill. At a later date, the CSAVR will submit written testimony on the aspects of H.R. 5700 which focus on disability determinations.

STATEMENT OF THE COUNCIL OF STATE ADMINISTRATORS OF VOCATIONAL REHABILITATION

The Council of State Administrators of Vocational Rehabilitation is an association composed of the chief administrators of all of the state agencies providing rehabilitation services to physically and mentally disabled persons in the states, the District of Columbia, and the territories. Through its Committee on Social Security Relationships, and the Disability Determination Services Subcommittee, the Council interacts with the Social Security Administration (SSA), the Rehabilitation Services Administration (RSA), and other groups with respect to issues affecting the Disability Insurance Program (Title II), the Supplemental Security Income Program (Title XVI), and the Beneficiary and SSI Rehabilitation Programs. The Council's Disability Determination Sevices Subcommittee, comprised of ten State Disabiltiy Determination Services Administrators, one from each of the ten Federal regions, is charged with matters affecting the disability determination process.

The CSAVR previously provided this Subcommittee with both written and oral testimony regarding Section 17 of H.R. 5700. The Council would now like to provide the Subcommittee with written testimony on those Sections of the proposed bill which would directly affect the Disability Determination Services (DDS), those state agencies which make the adjudications of disability under the Social Security Act.

There are three specific sections of H.R. 5700 which, if enacted into law, would directly impact upon the disability determination services. These three sections are: Section 5, Closing of the Record on Applications Involving Determinations of Disability; Disability Decisions, Appeals, and Reviews; Section 9, Additional Insured Status Requirement; Section 16, Payment for Medical Examinations in Making Disability Determinations.

Section 5 of H.R. 5700, contains three major provisions. First, it would lengthen the period of time in which a "denied" or "ceased" claimant may file for "reconsideration" of the unfavorable adjudication. Second, this section would restrict the admission of new evidence into the record after the DDS Reconsideration decision, and third, Section 5 would provide for a face-to-face evidentiary hearing at the reconsideration level for beneficiaries who were found through adjudication to have medically recovered.

Lengthening the reconsideration appeal period from 60 to 180 days, as Section 5 would provide, is not expected to significantly alter the timing or the number of Reconsideration applications. While it would be advantageous to the DDS to review a claim after a three (3) to six (6) month interval, thereby enabling the DDS to consider the deterioration or improvement of a medical condition, most claimants can be expected to file a request for Reconsideration within sixty days in the attempt to receive a disability benefit check as soon as possible. The Council of State Administrators of Vocational Rehabilitation does not oppose this provision, but does not believe that it will have the desired effect.

The provision in Section 5, which would restrict the admission of new evidence into the record after the DDS reconsideration decision would also allow the Secretary of Health and Human Services to remand the case back to the DDS for "further consideration," where new evidence or new allegations of a disability are presented after the Reconsideration decision. As a result, this provision would reduce the disparity between the DDS and the Administrative Law Judge adjudications by restricting both adjudications to the same evidence. However, a price would be paid for there would be the cost of an additional DDS adjudication in those instances where there is new evidence. The CSAVR does not oppose this provision if the U.S. Congress and the Social Security Administration allocate additional funding for the DDS to make these additional adjudications.

Section 5 of H.R. 5700, would also require face-to-face evidentiary hearings as a part of the medical termination Reconsideration process. The CSAVR is concerned that this provision would present significant logistical difficulties for all states (especially large states such as Texas, California, and others). The time required to conduct such hearings, and the logistical reorganization of staff, files, office equipment, etc., which may be needed to comply with this section in an efficient manner, may indeed prove to be burdensome. The CSVAR strongly recommends that the Subcommittee replace this provision with a provision which would require a face-to-face interview of the beneficiary by the Social Security District Office prior to any Continuing Disability Examination.

Section 9, of H.R. 5700, would require the claimant to have worked in two of the six calendar years prior to the onset of disability. The CSAVR is not opposed to this provision, since it is expected to affect only a small number of claimants, and will not significantly affect the DDS operations.

Section 16, of H.R. 5700, would provide for a contract between the Social Security Administration and a fiscal agent (which could be a Medicare carrier) to determine rates and make payments for consultative examinations. The CSVAR is strongly opposed to the DDS relinquishing control of payments for consultative examinations.

Control of payments is the primary means by which the DDS manages the responsiveness, quality and timeliness of sources of consultative examinations. Furthermore, Medicare carriers historically have been associated with payment delays. Delayed payments or the expectation of delayed payments will have a negative impact on the DDS relationship with the medical community, and will make it very difficult for the DDS to solicit and maintain a panel of consulting physicians.

The CSAVR recommends any of the following alternative provisions as a means of addressing the problem of "volume providers:"

Social Security Administration examining centers;

Allowing the DDS to pay the prevailing fees for consultative examinations;

Vesting the independent fiscal agent with payment and accounting responsibilities only, and allowing the DDS to retain the responsibility for approval of payments; or

In the brief review of other sections of H.R. 5700, the CSVAR is enthusiastically supportive of Section 6 (Own Motion Review) and Section 7 (Guidelines for Disabilities Determinations). The CSVAR is also supportive of Section 8, Evaluation of Pain, if the guidelines for evaluating pain by the DDS and the Administrative Law Judges are identical.

The CSVAR appreciates this opportunity to present its views on H.R. 5700, the "Disability Amendments of 1982."

Chairman PICKLE. Thank you, Mr. Galotti. Mr. Phelan, did you want to make any additional statement?

Mr. PHELAN. No; not at this time.

Chairman PICKLE. You support his presentation?

Mr. PHELAN. Yes.

Chairman PICKLE. I would ask you, Messrs. Galotti and Lomax, you represent your national associations. Your testimony in effect is the position of your national group?

Mr. GALOTTI. Yes, sir.

Mr. LOMAX. Yes.

Chairman PICKLE. Mr. Cox, we would be pleased to hear your testimony.

STATEMENT OF JAMES ALLEN COX, JR., EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Mr. Cox. Thank you, Mr. Chairman. I am Allen Cox, executive director of the National Association of Rehabilitation Facilities. Our organization is a national, voluntary group of over 700 nonprofit community rehabilitation centers which engage in providing comprehensive rehabilitation services to an estimated 400,000 disabled people annually. Many of these people are social security disability insurance and supplemental security income disability beneficiaries.

I have submitted complete testimony for the record and will summarize a few of the major points at this time. We address primarily section 17 of H.R. 5700, which would amend the beneficiary rehabilitation program for both SSI and SSDI beneficiaries. The Congress did not accept the President's fiscal year 1982 proposal to repeal the program. Instead, it retained the program but made amendments in the Omnibus Budget Reconciliation Act of 1981, which we believe render the program useless.

We commend the committee for trying to breathe some life back into the program. We believe that the amendment rendered the program useless because while it allows payment in advance the Social Security Administration has said it will not make any advance payments, and further because there is no financial incentive for States or community rehabilitation facilities to participate in the program.

The bill goes a long way toward solving some of these problems. It requires payment in advance and we support this change. The bill would allow the Commissioner of the Social Security Administration to contract directly with public and private organizations to provide vocational rehabilitation services. Payments would be made through a transfer from trust funds for the cost of these services. We support these amendments.

NARF has sought to have direct referrals made to community rehabilitation facilities in order to expedite evaluation of clients, preparation of a rehabilitation plan and delivery of services. We commend the committee for taking this approach. We have been frustrated that the demonstration authority to allow direct referrals still has not moved forward from the Social Security Administration.

We recognize the bill expands the scope of payment of services beyond solely successful rehabilitations and further requires demonstration projects within the stated period to explore ways to use the private facilities to provide services. We note, however, that the references seem to focus on private for-profit corporations and do not clearly identify that nonprofit private corporations might also be engaged.

While the bill proposes to expand the circumstances under which a State or facility would be reimbursed for services, both the communities facilities and the State agencies will be at risk for their good faith efforts to rehabilitate the beneficiary that does not result in a successful rehabilitation.

The State agencies may utilize the basic State grant funds available to them under the Rehabilitation Act to cover the cost of unsuccessful rehabilitation. But we note the significant curtailment in the availability of basic State grant funds and the subsequent curtailment in activity and rehabilitation of SSI and SSDI recipients.

Facilities, however, would have to incur a direct loss for any persons served for whom they do not receive reimbursement in the event that that person is not successfully rehabilitated. This would be an impossible situation for the already severely taxed nonprofit community facilities to begin or continue services to a group of people for whom there is no guarantee of reimbursement of those costs.

As drafted, there is no way to cover the cost of serving the failures. Even the best evaluation techniques employed in screening cannot guarantee 100 percent success. Therefore, Mr. Chairman, we recommend that when community facilities contract directly with the Social Security Administration that an overhead payment in recognition of the cost of unsuccessful rehabilitations be provided as a premium over the direct, actual cost of the service to those who are served in these facilities.

We suggest that this premium over the basic cost of service might enable the nonprofit private sector to serve successfully all of the referrals and not severely screen these referrals to accept only those who have the highest chance of rehabilitation. In the long run, the savings to the trust funds in terms of the higher number of successful rehabilitations will more than outweigh the cost. Both of these are consistent objectives of the program.

Mr. Chairman, the balance of my comments are in the statement for the record before the committee. I have no further comments. Thank you.

[The prepared statement follows:]

STATEMENT OF JAMES ALLEN COX, JR., EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Mr. Chairman, my name is Allen Cox. I am Executive Director of the National Association of Rehabilitation Facilities (NARF). NARF has about 700 members who provide comprehensive rehabilitation services to over 400,000 disabled individuals annually. Many of these are Social Security Disability Insurance beneficiaries and Supplemental Security Income disability beneficiaries. My testimony today is addressed primarily at Section 17, HR 5700 to amend the beneficiary rehabilitation program. It also addresses several other sections of concern to NARF.

The SSDI program provides benefits and rehabilitation services to individuals determined to be disabled and therefore unable to work. It contains incentives for people to seek employment, however several disincentives still exist. Prior to the Omnibus Budget Reconciliation Act of 1981, the beneficiaries rehabilitation program, a main feature in returning the disabled to competitive employment, had managed to achieve a margin of success in returning people to work and removing them from the benefit rolls. However, the Omnibus Budget Reconciliation Act of 1981 amended the program and we believe rendered it useless. We support incentives and services to help beneficiaries to become self-sufficient. To this end we offer the following comments:

VOCATIONAL REHABILITATION PROGRAM (SEC. 17)

Prior to the Omnibus Budget Reconciliation Act of 1981, the SSDI vocational rehabilitation program authorized funds to be paid from OASDI trust funds to state agencies for services delivered to SSDI beneficiaries. The purpose of the program is to return beneficiaries to work, thereby resulting in savings to the trust funds.

In 1981 $124 million was available under the program for both SSI and SSDI beneficiaries. Approximately 150,000 people were served. Several studies were done of the program, all of which showed it to be cost effective.

In his fiscal year 1982 budget message, President Reagan proposed to repeal the program as part of his overall budget cutting effort. Congress did not completely accept this proposal; however, it did amend the program. The new provision provides that states will be paid, either in advance or by way of reimbursement for successful rehabilitations. A successful rehabilitation is defined as a person who is performing substantial gainful activity for nine (9) continuous months. SSA has issued proposed rules stating that it does not intend to make any payments in advance and that it anticipated only $3 million being available under the program for fiscal year 1982. States have until April to indicate whether or not they will participate.

There are several major problems with the statute as amended. First, the provision severely limits the availability of funds for rehabilitation of SSI and SSDI beneficiaries which will result in continued dependence of many beneficiaries on cash assistance. Also, states are expected to use funds under Title I of the Rehabilitation Act to provide services which hopefully result in a successful rehabilitation. If not, they are not reimbursed. Use by the states of these increasingly scarce funds for SSI and SSDI beneficiaries is unlikely given the uncertainty of reimbursement.

Funds for the basic state grant program under Title I of the Rehabilitation Act of 1973 have been diminishing steadily. In fiscal year 1981, $854.3 million was available to serve disabled people. The program was increased only marginally by approximately 5 percent for fiscal year 1982, to $863 million of which 51 percent has been obligated to date. In his fiscal year 1983 budget request, the President has proposed a $91 million recission for fiscal year 1982 which would leave only $331 million available for the balance of this fiscal year. For fiscal year 1983 the President has requested only $579.5 million for state grants. According to recent figures from RSA, 353,000 fewer people will receive services at this fiscal year 1983 level. This is 28 percent below the 1982 levels. This potential decrease from the fiscal year 1982 levels is in addition to the expected decrease from the 1981 to 1982 and the 9 percent decrease in services from 1980 to 1981. Given the virtual elimination of the beneficiary rehabilitation program, cuts in the basic state grant program will be reduced to the lowest possible level, turning away numerous clients including SSI/SSDI beneficiaries.

We believe Section 17 goes a long way toward resolving some of these problems. We do, however, have several comments.

The bill would require payment for services delivered to be paid in advance. We support this change.

The bill would allow the Commissioner of the Social Security Administration to contract directly with public and private organizations to provide vocational rehabilitation services. Payment would be made through a transfer from the trust funds for the costs of these services. We support this provision. NARF has sought to have direct referrals made to facilities in order to expedite evaluation of clients, preparation of a rehabilitation plan and delivery of services. We commend the Committee for taking this approach.

The bill also expands the scope of payments to include evaluation services, services contributing to medical recovery, and services delivered if the person without good cause fails to continue to accept vocational rehabilitation services or fails to cooperate in addition to paying for successful rehabilitations. While this expansion of circumstances for which services will be paid is helpful, it leaves open the question of covering the cost of delivering services for unsuccessful rehabilitations.

If the program is going to reimburse facilities or states only in these four circumstances, both facilities and states will be at risk for good faith efforts to rehabilitate a beneficiary that does not result in a successful rehabilitation. The state agencies can use basic state grant program funds to cover such costs. Such funds would otherwise be available for clients under that program. State agencies would have funds to draw upon and not risk an outright loss. For facilities, they would have to pay funds for services out of their own capital which means that they would be decreasing their service capacity. It would be imprudent for the trustees of a facility to accept referrals if they must pay the cost for services whether the rehabilitations are successful or not, unless there is potential for financial reward with the risk. As drafted there is no way to average out the failures. Even the best evaluation techniques do not grarantee 100 percent success.

Therefore if facilities accept such referrals and the risk of nonsuccessful rehabilitations, there should be an incentive and reward for doing so. If the only cost paid is for successful rehabilitations and none for unsuccessful ones, the facility can, at best, only come out even. Actually they will always be losing funds.

We recommend that in those instances where facilities contract directly with the Commissioner, that an incentive payment in the form of a premium over cost be included in facility payments. We suggest a premium over cost of services retained, recognizing that if such services are not successful, reimbursement will be zero.

The bill proposes to pay states for vocational evaluation and job placement services provided to people who medically recover and who are determined to be no longer disabled as a result of a continuing disability investigation. Such services are needed by people who have been disabled and not working to help them determine and learn employment skills. We recommend that the legislative history make it clear that states can contract with private rehabilitation facilities for these services.

The 1980 SSI/SSDI amendments established an experimental and demonstration project authority. The bill would expand this to include exploring ways to use private rehabilitation facilities to provide services to beneficiaries. It speaks in terms of organizations organized for profit and those not so organized. The current language favors the for-profit sector. If the intent is to include both private for-profit and nonprofit organizations, we recommend that it should be specifically so stated. We do support the idea of demonstration projects with rehabilitation facilities and placing specific time limits on the Department to conduct the projects. To date it has not implemented the section of the 1980 amendments establishing an experimental and demonstration project authority.

CONTINUED BENEFIT PAYMENTS (SEC. 2)

We have received reports from our members of the number of people undergoing review of their disabling condition pursuant to the 1980 amendments. Many of these beneficiaries have not been reviewed in years and are suddenly faced with a loss of benefits before their appeal is exhausted.

We support this provision to allow SSDI beneficiaries to continue to receive benefits through the appeal period as do SSI beneficiaries currently.

ADJUSTMENT BENEFITS (SEC. 3)

This provision would allow a person terminated as a result of the continuing disability investigation currently being conducted to continue to receive benefits for 4 months after the month he is notified he is being terminated for medical recovery. This provision would be in effect through 1984 by which time all the rolls will have been reviewed. Such people could also receive vocational work evaluation and job placement as proposed in Section 17. We support this provision as a way of easing the economic shock of a sudden loss of benefits and helping people obtain employment.

OWN MOTION REVIEW (SEC. 6)

This section requires the Secretary to review a certain percentage of administrative law judges' opinions that people are or continue to be under disabilities. We recommend that the Secretary be required to review a similar number of decisions that people are not under a disability in order to be equitable in the review of ALJ's decisions.

SUBSTANTIAL GAINFUL ACTIVITY (SGA) AND THE TRIAL WORK PERIOD (TWP) (SEC. 10)

This provision is intended to raise SGA and to link it and the amounts attributed toward a month of the trial work period to the cost of living increases used for social security recipients. We generally support this proposal, but have two concerns. First, any calendar month in which a disabled recipient earns less than the substantial gainful activity earnings test amount, currently $300, should not be counted as a month of trial work.

Under existing Social Security Administration regulations, any calendar month in which a disabled recipient earns more than $75 in gross wages may be counted as one month of the trial work period. This regulation makes it possible for disabled employees of sheltered workshops to exhaust all or part of their trial work period before they are ready to attempt independent, community employment. For example, evaluation and training involve productive work in providing such services. And especially in the case of the more severely handicapped such training is extensive and may exhaust the trial work period. We are unaware of any justification for the $75 earnings level for a trial work period month. Even by linking this amount to COLA increases, the test will continue to deprive many sheltered workshop employees of a meaningful trial work period. Because this requirement performs a substantial disservice to disabled workers, we recommend that it be removed.

Another problem associated with the trial work period is the confusion regarding what remuneration constitutes income, which is denoted as "services" in the statute. In the bill, "Services" are to be defined as activity which is determined by the Secretary to be of a type normally for remuneration or gain or which is performed for remuneration or gain. Currently there is no specific list of such services in the SSI Claims Manual or elsewhere.

In determining a TWP month, disparate sources of income are considered to constitute services. For example, one inconsistent source of income used to determine a TWP month is the CETA training allowance under Title II. These funds are counted against TWP income, but are specifically excluded from income in determining SSI eligibility.

If income is to determine the existence of "services" for purposes of TWP, the type of income that constitutes services should be consistent in determining eligibility and SGA. We recommend the Committee examine this issue in consideration of H.R. 5700.

Productivity as measured by income, not the work attempt, should determine SGA.

Second, the amount that constitutes SGA should be monitored to assure that it does not increase to a level where it becomes a disincentive to learning the program and seeking competitive employment.

PROGRAM OF TRAINING AND CONTINUING EDUCATION FOR PHYSICIANS AND OSTEOPATHS; ADVISORY COUNCIL ON MEDICAL ASPECTS OF DISABILITY (SEC. 11)

This section proposes to establish an Advisory Council on the Medical Aspects of Disability. Membership on the Council is to include people from hospital, medical and other health activities. We recommend that rehabilitation be added after the word "medical" and therefore be recognized explicitly for its role in the disability area.

ATTORNEYS' FEES (SEC. 13)

This section would forbid the Government from paying attorneys' fees for claimants. Currently HHS establishes a reasonable fee which is paid out of the claimant's past due benefits. Also a court can set a reasonable attorney's fee.

We believe eliminating payment of fees under the program and removing it from the Equal Access to Justice Act would chill the desire of some legitimate claimants from pursuing their remedies. These proposals should not be adopted.

Thank you. I would be pleased to answer any questions.

Chairman PICKLE. Thank you, Mr. Cox. Your entire statement will be put in the record.

Now I appreciate the testimony of all three of you individuals. In general you give me the feeling that you support the bill and we needed the changes and that you support H.R. 5700.

Yesterday we had testimony from people who were not quite as agreeable as to two main areas. The first was the question of closing the record at the reconsideration level and some of the attorneys who testified yesterday said that would be going too far, that would be denying justice to a lot of claimants who really do not see an attorney until after the reconsideration level.

Now, Mr. Lomax, I believe you had stated—I think I have your testimony here—the claimant has been told by the attorney not to submit additional evidence or go to an examination that would slow their appeals. You say closing the record at the reconsideration level will close this loophole that attorneys now exploit. Now that is a pretty broad statement, a pretty strong statement.

But I presume by making that statement that is a common practice that many attorneys follow today.

Mr. LOMAX. To our knowledge it is a common practice in situations where we get into what we consider volume attorneys, in which they advertise that they will represent claimants before the appeals process and they encourage claimants not to submit additional evidence or go to examinations, then ask the State agencies to make a decision as soon as possible on the claim so that they can get to the appeals process.

Chairman PICKLE. If we were to move up the closing the record at the reconsideration level, would we deny the rights of claimants to have that case promptly heard or represented by an attorney?

Mr. **Lomax**. No. Attorneys often submit additional evidence at the reconsideration level and get involved at that particular level. No one is being denied, as far as I can understand, his right to have an attorney on their behalf at the reconsideration level.

Chairman **Pickle**. I am glad to have your testimony because we are trying to find a better way to move these cases out, have face-to-face evidentiary hearings at an earlier point. I note from your testimony that you think that would be in order.

Mr. **Lomax**. It is the feeling of the association and the survey we did take that the examiners would be very much in favor of the evidentiary hearing for the determination of those individuals that are being terminated their benefits

Chairman **Pickle**. You state, Mr. Lomax, that paying the prevailing fee will interest more physicians in doing exams for State agencies and you state that some States now pay more than the prevailing rate.

Mr. **Lomax**. That is correct.

Chairman **Pickle**. And you should have some alternative. I would point out to you on page 51, I think, of our bill you make this provision, that the Secretary may increase the payment amounts under this subparagraph where the State applies to the Secretary for such increase if the Secretary determines that such increase is necessary, at his discretion.

Mr. **Lomax**. If I understood that section of the bill, it was also tied to the fiscal agent, if I am correct. If not, I stand corrected. But I wanted to point out that we were not in favor of the fiscal agent but we were in favor of the prevailing fees.

Chairman **Pickle**. What is your objection to a fiscal agent? We are trying to find evidence. We want to get a record. We have an awful time even finding records of any kind under the consultative examinations now. We have been trying not to change the amount of money or questions. We just want to get the evidence.

If we had a fiscal agent, at least it would have to—what is your objection to having a fiscal agent or carrier?

Mr. **Lomax**. Our main objection to a fiscal agent is setting up another bureaucracy to handle something that has already been handled. What has not been handled in the past——

Chairman **Pickle**. Who handles it now?

Mr. **Lomax**. State agencies. They are paying the bills.

Chairman **Pickle**. But when they pay the bill, a lot of times we understand that they do not have the record to pay or they do not know how to pay it. We cannot get any information for them. We ask for some records. They might just as well be baying at the moon.

Mr. **Lomax**. As I pointed out in my testimony, the State agencies were never asked to provide this information in the past and have not been asked to keep records on individual volume providers or providers of medical records.

State agencies could—if they had been asked to do this—submit in the future statements as to how much each provider has been paid, if that is the wish of the Congress. But what I am stating here is I cannot see, and the association cannot see, setting up a fiscal agent or third party to handle the billing part, when States were never asked to do this in the past.

As I go on to state in my written part here, is who obtains the medical evidence of record? Is the State still going to do this? If this is so, then you are having really two different agencies handling separate parts of the medical fees part.

Chairman **PICKLE**. The committee is simply trying to find out a way to make an evaluation of these exams and determine how many they examine. Where are the records? Who has the information to pay? At this point we are not having a workable relationship with the State agencies.

Mr. **LOMAX**. I share that concern with you, but I also share the concern that the States have not been asked to keep records in the past to provide this information. I have definite questions about a third party in this situation here, of having a fiscal agent handle part of the State agency's funding or billing process in this regard.

As you probably know, SSA has come under fire recently with medicare and the number of people that were supposedly dead on the rolls as far as medicare was concerned because that has been handled through a third party or another agent in the Kansas City region. A bulletin just issued February of 1982, and was received in our agency March 15, 1982.

Kansas City was looking into 55 cases that were supposedly dead on medicare rolls and in that investigation they found 23 were still alive. Now if this is a concern of the fiscal agent and how it will be handled as a fiscal agent and whether or not we can really trust whether or not the bills will be paid timely, whether or not the right amounts will be generated to the right vendor and so forth. That seriously raises questions in my mind.

Chairman **PICKLE**. Mr. Gradison, do you have any questions?

Mr. **GRADISON**. No.

Chairman **PICKLE**. Do any of you wish to make any additional statement other than the testimony? I am glad that you concentrated on section 17. Overall, you seem to believe that this is the right approach—the advance funding—that is understandable.

Do you wish to make any additional comments other than the testimony?

Mr. **COX**. No, sir, not at this time.

Chairman **PICKLE**. I hesitate to ask a lot of other questions because you are in general agreement with our position. We had better rest our case.

Thank you. Now the Chair would ask Mr. Richard Peckham if he would take a seat. Mr. Peckham is a member of the board of directors of the Association of Staff Attorneys, the Office of Hearings and Appeals. Tell me more about your association. Are you based here in Washington?

STATEMENT OF RICHARD PECKHAM, MEMBER, BOARD OF DIRECTORS, ASSOCIATION OF STAFF ATTORNEYS, OFFICE OF HEARINGS AND APPEALS

Mr. **PECKHAM**. No, we are a loose association of staff attorneys who work in the Office of Hearings and Appeals from all over the country. We actually have officers spread out all over the country We have no headquarters per se at this point.

Chairman **Pickle**. Are you concerned with cases that have been appealed?

Mr. **Peckham**. That is right.

Chairman **Pickle**. At the ALJ level and above?

Mr. **Peckham**. That is right. For the last 5 years I have acted as a staff attorney to administrative law judges who process these claims after the initial appeals at the initial and recon level. I have personally written, drafted, recommended and drafted 1,600 of these cases. I am here to talk first about the bill and then briefly about the staff attorney position vis-a-vis advancement.

Chairman **Pickle**. We are glad to have you, Mr. Peckham.

Mr. **Peckham**. Thank you, sir.

First let me say that the staff attorneys generally support the 1982 Disability Amendments in the form of H.R. 5700. Of special interest is the proposed Social Security Court, which will eliminate confusion and promote greatly needed uniformity at all levels of the now fragmented disability determination program.

H.R. 5700 also recognizes a serious procedural deficiency in the fact that the State agencies are making determinations based on a standard of disability which is not required by the Social Security Act and regulations. That is, the State agencies are judging all claimants by whether they meet or equal in severity the listing of impairments found in appendix 1 of regulation 4.

However, the regulations actually state that only a narrow class of claimants, principally widows, is required to meet the high standard of the listing of impairments. On the other hand, 95 percent of the disability claimants are, by regulation, held to an entirely different and less stringent standard.

For administrative convenience, among other reasons, the Social Security Administration has improperly urged the State agencies to require the listing standard in all cases and the results have been very expensive. In Kansas, the State agency improperly applied the listing standard to a 60-year-old heart patient with multiple coronary bypass surgeries. He had a treadmill stress test indicating severe ischemia, a condition rendering him unfit for even sedentary work.

The agency denied his claim for failure to meet a specific electrocardiogram tracing level found in the listing of impairments that the claimant's physician and the State agency physician acknowledged that the standards currently followed in the national medical community would demand a finding that the claimant was unfit for work of any kind.

However, the State agency physician, apologetically and incorrectly, stated that the Social Security Administration demanded application of the listing criteria. In fact, the law and regulations do not require the claimant in this case to meet or equal the listing standard and an Administrative Law Judge properly reversed the State agency determination.

This is a common example of what is happening in the disability determinations units in every State in the Union. The State agencies of the Social Security Administration management have bitterly decried the fact that the administrative law judges have consistently reversed a high percentage of these determinations. However, the judges have simply applied the standards prescribed by the law and regulations.

With two segments of the disability entitlement systems applying conflicting standards, the claimants are put to unnecessary expense and delay and grief, and the taxpayer is financing wasteful inefficiency involving millions of dollars annually. Predictably, Congressman then spend time answering the complaints of confused disability claimants.

The solution is to provide a quality determination at the State agency level at the initial determination level based on the standards found in the regulations. The Social Security Administration must follow its own regulations and properly educate the State agencies.

Chairman PICKLE. Mr. Peckham, let me interrupt you at this point because I think I would like you to tell me a little bit more about these listing of impairments and the standard, the criteria that they use. How does it work where the social security officer calls in a large number of people all over the country and the local SSA representative, for example, has to look at these people and they follow a certain guideline. You are disabled or you are not disabled.

Now these are not heartless people, but they have apparently been instructed by the social security office. You follow a certain guideline and though he may look like he is disabled and he cannot take a test, but unless he can take this treadmill test or other things you say he is eligible. Now tell me a little bit more how the procedure works and why is it we are having such a large number?

If they are denying 40 to 45 percent of these cases, they are doing it because—it has been charged that they are trying to save money, but they are trying to say you interpret very narrowly these criteria and the people who are making the examinations apparently must be hard put to do anything other than say you are eligible to work.

Now tell me a little bit more of the procedure. I want to understand how it works.

Mr. PECKHAM. This problem goes back at least 10 years. We are only seeing with the CDI's a magnification of the problem. It is nothing new. Well before this administration came in—two different standards. One is for widows.

The standard for widows is listed in a book called the "Listing of Impairments." You pick out cardiovascular impairments and people say electrocardiogram readings must say five mets or under for widows only. According to the regulations—and keep in mind the State agencies do not have the regulations. They have the recommendations and the policy statements of the Social Security Administration management from Baltimore.

The Social Security Administration is under great pressure to get these cases processed quickly. The caseload increases continually. They look for a way to process them as quickly as possible and they wind up putting everybody through the listing standard, not only widows. But the regulations are supposed to be held to the standard. It is a much higher standard.

The other standard is simply that the individual, the wage earner himself, which is 95 percent of the claimants, is only held under regulations in the act that if he cannot work substantial gainful activity for 12 months, it does not say that he must meet the listing and no one has said that he has to meet the listing.

There is a subtle problem in here in that everybody theoretically is under the same regulations, but social security is not advising those 50 State agencies what the regulations are. They are influenced heavily by political pressures such as the need to move cases faster. In the process, they have overrun the regulations.

Therefore, you go through the initial phase, the initial decision at the State agency level, and under the wrong standard you go up to the recon stage under the same wrong standard. And what happens then, you could go through six recons if you wanted. You are going to get the same result, in essence a rubber stamp all the way along.

When you get to the ALJ level, the only thing he is bound by is the Social Security Act and the regulations. They have the force and effect of law. The problem comes in. Obviously it would be as if you started a football game down at RFK Stadium. For the first half you had a crew of referees for football and the second half you changed it to soccer referees who knew nothing about football. That is what you have.

Naturally, the ALJ's are going to follow the standard and the regulations, which is the lesser standard for 95 percent of the claimants, the natural result all over the country.

I have processed cases from New York and from California and from Kansas, from Illinois. It is the same. Now you have some individual ALJ's that gyrate wildly, but the majority are in a pretty close group; 50 to 60 percent, they reverse those claims and the reason is because there is an entirely different standard. No matter how you adjust the initial phase in terms of cosmetically—more evidence, less evidence, et cetera—if you apply a different standard at the next level you have wasted your time and money.

Chairman PICKLE. What is provided for? Is there uniformity—the POM's?

Mr. PECKHAM. POM's is the expression of the Social Security Administration. All you do is mix in them an internal operating procedure manual. When the ALJ sits down with POM's, which is an internal operating procedure manual. That is all that is. It has not the force and effect of law at this point. If you elevate it to the force and effect of law, the ALJ on the one hand is going to have to hold— weigh them both and he is going to have to find that the act and the regulations take precedence, so it will not change the determinations.

It will not change it.

Chairman PICKLE. Are you saying that if we have the POM's made uniform for both the State and the ALJ's, that would not help the situation?

Mr. PECKHAM. The Social Security Administration defines "pain" in POM's different than the regulation and the act defines it. They are going to go with the act and regulations. You will have the same problem you had before.

Now it will not make any difference is all I am saying. Go ahead and leave it in there if you want. It cannot hurt. The problem is the basic standards are different the main locus of that—the generation of that problem is in Baltimore, Md. They are the ones that advise the State agencies what standards to apply and they are telling them the wrong standard.

If they want to change the standard, change it, but by the time it gets to the ALJ he is bound by the regulations.

Chairman PICKLE. We will look into that further. I have a better idea of it.

Mr. Arner has a question. Mr. Arner.

Mr. ARNER. I think we maybe have a question here. As far as I know, the POM's provide for a sequential evaluation of disability where you do apply the vocational factors. Now you are saying that the Social Security Administration is telling the State agencies not to apply the vocational factors.

Now the POM's provide for applying the vocational factors. Are you saying that the State agency—the Social Security Administration is telling them to ignore the POM's because I do not see much difference between the POM's and the regulations in this area.

Mr. PECKHAM. Under everybody's standard you go first to the medical and then if the medical is not determinative you go to the vocational under everybody's standard.

The problem is the definition of medical—two different standards.

Mr. ARNER. But you were saying the Social Security was requiring them to meet the listings.

Mr. PECKHAM. In essence.

Mr. ARNER. Well, you see, that is different than having a significant impairment and then define the vocational factors.

Mr. PECKHAM. It is subtle in that it is not all down on paper in a nice clear form.

Mr. ARNER. That is what I am trying to say. Are you saying they are doing something other than what is in POM's?

Mr. PECKHAM. Yes, yes. That would be true. I am sorry. You are right. That is true.

Social security, all different levels are technically saying that they are under the same system. The ALJ is only reading the regulations. He is bound by that. At the lower level they do not even see the regulations. They are not reading the two definitions. They read a prepared POM or whatever it is, an internal memo that comes from Baltimore that tells them how to handle the cases.

Mr. ARNER. But you say they are getting instructions here that are somewhat different from POM's is what it boils down to.

Mr. PECKHAM. Yes.

Chairman PICKLE. Don't we have a problem also at the local level up to the reconsideration level also, that when a person is called in and they say we are going to examine you and he says my doctor tells me that I ought not to work, I should not take this examination, I am disabled. They get the letter from the doctor. The SSA examiner at that point cannot take into consideration the doctor's opinion as such. He is supposed to have medical evidence; is he not?

Mr. PECKHAM. Yes.

Chairman PICKLE. Doesn't that make for some misunderstanding at the local level? They feel in his heart that fellow—they just cannot take somebody's statement. He has to have the medical evidence.

Mr. **Peckham.** Not only that. At the local level the local physicians do not know the social security definition of disabled. It is total disability. The local physicians pick out a machinist who have been standing on his feet. He is 50 years of age and they say he cannot go back to that job because of his back, but he can do light sedentary work under our definition.

There is an element of that that definitely is involved and there is no way around that. But there is no question that a large number of these CDI's, and not just CDI's. I see this. I came on 5 years ago. The first judge I worked for I said this is ridiculous. We have two different standards. He says, I know. That was 5 years ago.

I cannot tell you how many cases I have written now where I can see the tax dollar just being wasted. It would eliminate an enormous number of these cases at the appeal level if you had one standard, but you are going to have to convince the folks in Baltimore.

Chairman **Pickle.** Well, Mr. Peckham, let me ask you to go ahead with your statement on page 4 or however you want to have it. Pardon my interruption.

Mr. **Peckham.** All right. I will now focus on the need for proper career advancement of staff attorneys in the Office of Hearings and Appeals. In his prepared statement, presented to this committee in October 1981, OHA Associate Commissioner Louis Hays told you that, "Attaining and maintaining an ALJ corps of 800 may be difficult to accomplish, considering the problems we have experienced in the past in obtaining adequate numbers of qualified candidates."

I have good news for Mr. Hays. He has a bountiful supply, a bumper crop of such qualified candidates alive and well within his own agency. In his testimony before this committee on October 28, 1981, my colleague, Dale Buchanan, offered evidence that the corps of staff attorneys assisting the administrative law judges has ripened from a temporary field support program to a permanent cadre of professionals who must now be considered experts in working with the complex body of law and regulation controlling the social security entitlement program.

The OHA staff attorney concept was originally designed as a 2-year program to alleviate the ALJ's of decision-writing duties at a time when the case backlog reached crisis proportions in 1975. The position was to expire in 1977, but its success was overwhelming. The need for professional assistance continued and the position was made permanent.

However, the Office of Hearings and Appeals and the Office of Personnel Management forgot to develop an appropriate career ladder for proper advancement of these new professionals in keeping with their potential contribution to the agency. As a result, a mature professional resource of great value to the disability adjudication program is now in danger of rotting on the vine in that they are being artificially, though inadvertently, prevented from qualifying for the administrative law judge position, which is the logical goal of lawyers trained in all aspects of the social security law and administrative hearing procedure.

Two years ago, in his affidavit of October 18, 1980, Daniel Skoler, OHA's Deputy Associate Commissioner for Program, stated that the staff attorneys were then capable of performing the hearing officer function. *McClure* v. *Harris* even forcefully restated that position, in a second Federal district court case in 1981, the *Blankenship* case.

The staff attorneys had been told by the OPM that their agency experience is partially qualifying for the GS-15 ALJ position. However, because they are career capped at a GS-12 and are not performing at the GS-14 career level they do not meet the "level of experience" requirement, a technical obstacle.

The current ALJ selection criteria were instituted by OPM prior to the creation of the staff attorney program, now numbering about 450 employees, and did not contemplate this corps of professionals, uniquely qualified and expert in all aspects of disability adjudication. They are now performing all the significant duties of a hearing officer, with the exception of actually conducting the oral hearing.

The staff attorney weighs the value of hearing testimony, medical and vocational evidence, and prepares recommended decisions for the ALJ. He also determines the need for additional evidence, conducts prehearing conferences with claimants and attorneys and recommends dispensing with the hearing in those cases where his judgment finds the claimant's position well supported by the record evidence.

This performance level now substantially exceeds the GS-12 job description used by OPM as an artificial barrier to appropriate advancement. The job description no longer reflects the actual performance and professional stature of the OHA staff attorney.

Example: Richard Brown, staff attorney in the Portland, Oreg., hearing office, served 4 years as legal counsel with the U.S. Coast Guard, including a hearing officer function before returning to the staff attorney corps in 1975. He is now one of the best qualified for the ALJ position, yet barred by the artificial gap between GS-12 and GS-14.

Staff attorneys, if advanced to the ALJ position, are far more likely to render uniform hearing decisions consistent with the law and regulations than would be the case with lawyers selected from outside the agency without knowledge of the complex body of law and administrative hearing procedure. The cost to the taxpayer is reduced in that staff attorneys are capable of conducting administrative hearings today, whereas inexperienced lawyers selected from off the street require more than a year of training to become minimally proficient with social security law and procedure.

In recent years, the Japanese industrialists have reminded us of the efficiencies of promoting from within, taking full advantage of personnel matured by years of exposure to all phases of corporate operation. The same principle applies within large governmental organizations relying heavily upon highly specialized technical and professional skill, best developed from inside the organization.

Therefore, we ask the committee to take the following specific action:

One, to require the Office of Personnel Management to recognize all OHA staff attorneys currently possessing the requisite 7-year aggregate legal experience, including at least 2 years at the GS-12 staff attorney position as "experience qualified" immediately for purposes of the GS-15 administrative law judge register.

Two, to require the Office of Personnel Management to establish within 60 days a career ladder from the entry level staff attorney position to the GS-15 administrative law judge position.

Third, in the alternative, to accomplish the same two measures through legislation by incorporation in the Disability Amendments of 1982.

The public interest is best served by the most efficient use of professional Federal employees. Your interest is greatly appreciated.

Chairman PICKLE. Well, Mr. Peckham, I think you make a good point. The staff attorney problem, a problem that has been with us for a long time, 4 or 5 years, it has been an ongoing battle. I think you know that we had invited the Office of Personnel Management to appear before this committee and submit testimony. We invited them last fall and they excused themselves. We have invited them to appear at this time in connection with the bill, and they have declined.

And we have to ask ourselves why. We understand that they have said that after consultation with the Office of Management and Budget, they think the administration view would be most appropriately presented by the Department of HHS on matters pertaining to this program. So we are seeing a continuation of evasive indecisions that keeps us from coming to a head.

I am not prepared to say that someone at the GS-12 level is automatically able to handle these cases, but we do need more ALJ's. There is a source; there ought to be some way that this matter can be resolved other than running for cover. And I do not think that the Office of Management and Budget has got any business trying to tell us how—what kind of examiners we should have at what level.

They are getting a lot more management—it is an ongoing problem. We are mindful of it. We hoped we could have had an additional statement this morning, but since they decided not to appear, we will have to see what else can be done.

Well, I thank you for your statement. I appreciate it. It was helpful, it gives me a better understanding about some of the procedures. We appreciate it very much.

Mr. PECKHAM. Thank you, Mr. Chairman.

Chairman PICKLE. Now we will have a panel of Mr. Mark Coven, Eileen Sweeney, Jonathan Stein, and Evan Kemp. We have three; we need one more. All right. Now we have Mr. Mark Coven. He is a senior attorney for the Gray Panthers.

Mr. COVEN. Senior attorney, Boston Legal Services.

Chairman PICKLE. You represent the Greater Boston Legal Services?

Mr. COVEN. That is correct, Mr. Chairman.

Chairman PICKLE. I see. Then we have Eileen Sweeney, attorney for the National Senior Citizens Law Center; and Mr. Jonathan Stein who is chief of the Special Project of the Community Legal Services, Pennsylvania; and then Mr. Evan Kemp. You are director of the Disability Rights Center, where?

Mr. KEMP. Washington, D.C.

Chairman Pickle. We are pleased to have all of you panelists with us. We will receive the testimony first of Mr. Mark Coven.

STATEMENT OF MARK COVEN, SENIOR ATTORNEY, GREATER BOSTON LEGAL SERVICES

Mr. Coven. Thank you, Mr. Chairman. My name is Mark Coven, I am a senior attorney at Greater Boston Legal Services. In my position I represent many persons who have either had initial applications for social security or supplemental security income disability benefits denied or who have been determined eligible but later terminated after redetermination.

My program has represented literally hundreds of persons in these situations in the last years. If I may digress for just a moment, Mr. Chairman, I must say that the other major part of my legal practice is in the medicaid area, and it is indeed a pleasure to appear before the author of the Pickle amendment, perhaps the most well-known provision in the medicaid area that has allowed literally thousands of elderly recipients who lost their SSI benefits because of social security cost-of-living increases to retain much needed health care benefits in the medicaid program.

I just want to express all our appreciation for that very important provision.

Chairman Pickle. I appreciate your comments.

Mr. Coven. I appreciate the opportunity of appearing before you today because I am deeply concerned with two particular provisions of H.R. 5700; that provision that would close the record for evidentiary matters after reconsideration, and that provision which provides for hearings before the State agency after reconsideration and limiting administrative law judges to review of the record only.

I am concerned with legislation which would provide additional authority to the State agency because that agency is not capable of adequately performing its present responsibilities and simply lacks the capacity to perform additional and substantial duties.

That the State agencies cannot adequately perform their present responsibilities has become increasingly evident in the recent rate of terminations resulting from the continuing disability investigations. Members of this committee must be aware of what the proposed changes would mean in terms to the people in your districts who must rely on disability benefits as their only source of income and without which they are oftentimes left with absolutely no income.

A few cases of persons whom we have represented in recent terminations from the continuing disability investigations will best illustrate the total inability of the State disability determination service to do its job, and the harm that occurs to individuals as a result of the egregious acts of the State agencies.

Keep in mind that in these CDI investigations, each of the persons had previously been determined by the State agency to be unable to engage in any substantial gainful activity, and thus, disabled. And it is the same State agency that is saying that the same person is not disabled, even where there has been no showing of medical improvement.

Judy L. is an 8-year-old girl who has been on SSI for the last 4 years. She is afflicted by respiratory cystic fibrosis which causes severe breathing and energy problems and causes her lungs to fill up with phlegm each morning. The disease has also caused the development of polyps in her nose and throat which inhibits her respiratory function. As a result, she is required to have a yearly operation to relieve her polyps.

She has recently received notification that her benefits are being terminated and that she is no longer considered disabled.

Paul C. has had three inpatient hospitalizations for psychiatric breakdowns in the last 2 years. On each occasion he has attempted to physically harm himself. After being sent by the State agency for a psychiatric consultation where he was examined for less than 20 minutes, his social security benefits were terminated in September 1981. After filing for reconsideration, Mr. C. had a breakdown and was involuntarily committed to a psychiatric ward at Massachusetts General Hospital. The psychiatric nurse notified the State agency that Mr. C. would be committed to the inpatient ward for at least 5 months.

Despite the fact that he remains involuntarily committed, the State agency denied reconsideration without ever contacting his psychiatrist or psychiatric nurse at the Mass General.

Valerie S. is a severely brain damaged, 16-year-old girl. Over the last few years she learned to dress and wash herself and is in a special education class in the Boston public schools. In November 1981, Valerie's family received a notice from social security officials stating that, "Based on Valerie's work history, training, and education, she is no longer disabled."

Charles L. has spent most of his life in a mental institution, recently returned to the community. He lives in a rooming house and is able to get along only with substantial assistance. He remains hostile and has great difficulty relating to people. Moreover, Mr. L. has never learned to read. On October 13, 1981, he received a letter from social security officials stating, "Because of your education, work experience, and our evaluation of you, we find you ready to return to work." Mr. L.'s disability benefits were terminated on November 30, 1981.

The question which this committee must confront in H.R. 5700 is whether you want to assign additional responsibilities to agencies that make these types of decisions and cause this amount of harm to people entitled to and genuinely in need of disability benefits.

This committee should not be deceived into believing that these case examples are unique. They are common problems not only in the Massachusetts Disability Determination Service, but in other States as well.

Prior to the institution of the continuing disability investigations, we documented substantial problems with performance in the Massachusetts State agency in their disability determinations. After reviewing a sample of over 50 cases throughout Massachusetts, we concluded the following: the State agency failed to thoroughly investigate claims or to seek the most recent medical evidence; the State agency failed to accord proper weight to the reports of treating physicians; the State agency misused and failed to adequately monitor consultative exams; the State agency failed to develop information necessary to make fair determination of disability; the State agency was understaffed, overworked, and more concerned with timely processing of cases than with the quality of decisions; the State agency was applying incorrect and overly narrow standards of disability; it was virtually impossible to have a claim appoved by the State agency unless the claimant was floridly psychotic and unresponsive to treatment, or unless the claimant is institutional, pre-release; the State agency failed to consider the combined effect of a number of impairments or the effect of psychological impairments on physical limitations; the State agency is compromised by lack of staff, high staff turnover, heavy caseload and pressure for productivity at the expense of quality.

While we recognize the limitation of our analysis not being based on a scientifically selected sample, it does delineate the very real problems experienced by persons who were forced to rely on disability benefits.

This committee is being asked to transfer responsibilities now in the province of the administrative law judge to the State agencies. It is my position not only that the State agency does not have the capacity to perform these tasks, but that it is inappropriate for Congress to expect the State agency which denied or terminated benefits to be the party to hold impartial hearings to review its own decisions. It would be in their institutional interest to not reverse their own agency decisions. The administrative law judge, as a neutral party, is much more appropriate to fill this impartial role.

Further, claimants should not be foreclosed from submitting additional evidence after the reconsideration level. The State agencies do not thoroughly gather evidence. Oftentimes, claimants are represented only after the reconsideration level. Persons with physical or psychological limitations who are unable to gather medical evidence on their own should not be precluded from submitting new evidence which should be considered at each stage of the proceeding.

The question is whether the person is disabled. Evidence on that very issue should not be foreclosed or inhibited in any way.

These two provisions in H.R. 5700 could prove to be a disaster for the disabled. These are the people who have worked for their social security benefits and now, as a result of an impairment, can no longer work. These people are only asking that they receive fair and full consideration for benefits to which they may be entitled under the law, and which they desperately need.

We have already had too many suicides of persons who have lost their disability in the continuing disability investigations, and acted out of a sense of futility and desperation. The changes which I have noted contemplated by H.R. 5700 could only result in further dismay. I hope that this committee will not attempt to balance the social security trust fund on the backs of the disabled.

I would ask that a copy of our report on the Massachusetts Disability Determination Service be included in this hearing record as if read. Thank you, Mr. Chairman.

Chairman PICKLE. Your request that a copy of your report on Massachusetts Disability Determination Service will be included.

[The information referred to follows:]

REPORT ON THE MASSACHUSETTS DISABILITY DETERMINATION SERVICE (D.D.S.)

(Prepared by the Disability Task Force of Greater Boston Legal Services and Volunteer Lawyers Project)

I. STATEMENT OF PROBLEM

Pursuant to a contract made effective on June 27, 1966 and amended on June 12, 1970 and June 28, 1973, the Secretary of Health, Education and Welfare (now Health and Human Services) has entered into an agreement whereby the Massachusetts Rehabilitation Commission (hereinafter Mass. Rehab.) makes determinations of disability with respect to cases arising under Titles II and XVI of the Social Security Act. (A copy of that contract is appended hereto as Appendix I.) In making its determination, Mass. Rehab. is directed to employ the definition of disability or blindness established in the federal statute at Section 216(i) and 223 of Title II or Section 1614(a)(2) and (3) of Title XVI of the Social Security Act, and the federal regulations issued pursuant thereto. Mass. Rehab. has been assigned responsibility for disability determinations both on initial claims and on reconsideration where requested by the claimant after the initial denial of disability by Mass. Rehab.

In January of 1979, legal services staff and other advocacy groups from across Massachusetts who provide representation to disability claimants came together to discuss concerns about the disability determination service (hereinafter referred to as D.D.S.) performed by Mass. Rehab.[1] It was the unanimous sense of that group that persons were not receiving full and fair consideration of their disability claims by Mass. Rehab. and that a significant number of disability claimants, who were in fact eligible for benefits and desparately in need of that income, were having their claims denied as a result of incorrect disability determinations.[2] The impressions of this group were substantiated by: (1) the statistical history of the state D.D.S. (Mass. Rehab.); (2) reports of the General Accounting Office which raise similar issues; (3) other studies and reports concerning the state disability determination process; (4) research into the functioning of Mass. Rehab.; and (5) an analysis into approximately 50 cases in which an initial disability claim and request for reconsideration were denied by Mass. Rehab. and these determinations were subsequently reversed on appeal.[3]

A. *Statistical history*

In fiscal year 1979, 25,859 disability claims were filed for Title II (social security) benefits and 27,309 disability claims were filed for Title XVI (supplemental security income) benefits in Massachusetts. Of those initial claims, 13,901 Title II applicants or 53.8 percent and 14,028 Title XVI applications or 51.3 percent were denied by Mass. Rehab. This means that 11,958 Title II claims or 46.2 percent and 13,281 Title XVI claims or 48.6 percent were initially approved by Mass. Rehab. Of the 27,929 total denials, only 1,087 Title II claims and 776 Title VI claims were reversed by Mass. Rehab. on reconsideration. (These statistics are appended hereto as Appendix II.)

These figures indicate that in fiscal year 1979, 12,814 Title II claims and 13,252 Title XVI claims or a total of 26,066 persons who made application based on disability were denied benefits. This large number is significant because in fiscal year 1978, an astounding 53 percent of all disability cases that were appealed to administrative law judges were reversed and disability benefits awarded. If the fiscal year 1978 figure of 3,499 cases requesting appeals to an administrative law judge remained relatively constant in fiscal year 1979, it would mean that approximately 22,567 claimants never requested a hearing and went without disability benefits.

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[1] This group included representation from virtually every legal servies program in the State, as well as private practitioners.

[2] These claimants are almost always persons who are not working and must rely on the fixed income provided by Social Security Disability benefits or Supplemental Security Income benefits in order to survive in an inflationary economy. Persons who are wrongfully denied disability benefits are forced to exist on meager state welfare benefits or, in many instances, are deprived of any income whatsoever.

[3] The group's impressions were further sustained by the testimony proffered at the public hearing held February 27, 1980, regarding the Social Security Administration's proposed adversarial hearing experiment. Opposition to the proposed experiment was overwhelming, and the consistent response by those testifying was that the problems with the disability determination process were not at the hearing stage but rather in the initial disability determinations by Mass. Rehab. In announcing that the Social Security Administration would not go forward with its proposed experiment the Commissioner of Social Security, William J. Driver, stated that, "We have now taken a close look at the testimony received at the public hearings and the comments received in response to the Notice of Proposed Rulemaking on the Government Representative Experiment. Generally, the public was not in favor of the hearing experiment and offered suggestions on how we might improve the decision-making process at the initial and reconsideration stages, which precede the hearing level. As a result of the public comments and our recognition that improvements can be made at the earlier parts of the process, we have decided not to proceed with the hearing experiment at this time; we will explore alternative means for improving the overall adjudicatory process."

It can be assumed that a percentage of these 22,567 cases did not appeal because they did not believe themselves actually entitled to disability benefits. But it can also be assumed that a significant percentage of these 22,567 did not request appeals because they did not have and could not secure representation or because they did not have the stamina to push on. If this latter group comprised only half the total, and the 50 percent reversal rate remained accurate, the statistics suggest that roughly 5,642 individuals who were in need of and entitled to disability benefits were wrongfully denied those benefits as a result of the actions of Mass. Rehab.[4]

That there exists a 53 percent reversal rate of cases appealed from Mass. Rehab. denotes a real problem in and of itself. But the problem becomes far more significant when viewed in the perspective of the large number of D.D.S. decisions which are never appealed.

B. GAO reports

In August, 1976, the General Accounting Office issued a study of disability determination services nationwide entitled, "The Social Security Administration Should Provide More Management and Leadership in Determining Who is Eligible for Disability Benefits." In that report, GAO tested the uniformity of decisions by the state agencies as to persons eligible for disability benefits under Titles II and XVI of the Social Security Act and found that disability applicants do not receive objective, uniform and equal consideration of their claims. In fact, it was found that individual disability determinations would vary from state to state. The report emphasized the following problems in the disability determination service: 1. Criteria and guidelines provided to the State agencies to use in disability determinations often were incomplete, vague, contradictory, time consuming to implement, and subject to divergent interpretation.

2. The quality assurance system was not fully effective because:

The system was not properly established or functioning in all State agencies.

The trend analysis and special studies intended to correct systemwide problems were nonexistent.

The criteria for returning cases to the State for reconsideration and review were too restrictive.

3. There existed problems with the adequacy of the medical information and disability reports provided to the State agencies by the Social Security Administration's district and branch offices. Even though State agency officials had said this problem had an adverse effect on the efficiency of their operations, it had not been corrected.

In a follow-up report issued in August, 1978, entitled, "A Plan for Improving the Disability Determination Process by Bringing it Under Complete Federal Management Should be Developed," GAO again found that although the function of each disability determination agency is the same, rendering decisions as to whether or not a claimant is disabled, the means used to reach these decisions differ considerably among the States. Because of these differences and the inherent subjectivity of decisionmaking, GAO found that total uniformity of decisions may never be achieved.

Reviewing progress from its initial study, GAO found that Social Security's efforts to strengthen the present Federal/State agreements had met with little or no success. According to the report, this failure was principally attributable to the unwillingness of many State officials to relinquish prerogatives accorded the State under the present agreements—such as determining their own organizational make up, workflow process, and training programs.[5] Among its specific findings, GAO also found that there was inadequate participation of physicians in the disability determination process.

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[4] This number, of course, would be higher or lower depending on what assumptions are made concerning the reasons for failing to appeal to the ALJ stage.

[5] The GAO report also concluded that the Federal/State relationship is an impediment to improving the administration of the programs because of the (1) unanswered questions about the effectiveness and efficiency in the Federal/State relationship that have existed for almost 20 years; (2) questionable need for the process to be closely aligned with the State vocational rehabilitation activities; (3) inability of the principals to remedy contractual defects, such as clearly defining their responsibilities; and (4) need for social security to have more effective management and control over the disability programs.

A fourth report concerning the disability determination process was issued by the GAO in October, 1979. Entitled "Controls Over Medical Examinations Necessary for the Social Security Administration to Better Determine Disability,"[6] the report emphasized that State agencies are not following proper procedures for adequate development of medical information on claims. The report cited a memorandum from the SSA Financial Management Branch dated July 26, 1977, on the current status of funding for purchase of consultative examinations which stated:

". . . Unfortunately the conclusion from the survey was that many States are not following proper procedures which results in the purchase of many unnecessary CEs [consultative examinations]. . . ."

According to the report, the review in one State concluded:

"The results of the study indicate a gross inadequacy among the examiners/supervisors in distinguishing when a consultative examination is necessary as the next developmental step or when other sources within the folder should be tapped or expanded . . . . if annualized, the total amount of money spent unnecessarily would be $447,332."

The conclusion of the 1979 GAO report was that funds have been wasted on unnecessary, incomplete, or inadequate evidence. For example, the report stated that the results from five of a State agency's studies indicated that inadequate consultative examination reports were obtained about 68 percent of the time. Many of these reports were so inadequate that a disability decision could not be made without further information.[7]

The series of GAO reports illustrates the historic and continuing problems in the State disability determination service. This historic perspective is particularly important in understanding the reason that, of the claims allowed, a decreasing number are allowed on initial determination at the State agency level, and an increasing number on appeal, particularly at the hearing level. Through 1968 about 90 percent of awards were made at the initial level (over 93 percent in 1961 and 1963). However, beginning with 1969 this percentage has declined gradually to a low of 82 percent in the year ending June 1977.

ALLOWANCES

Year	Initial (State)		Reconsideration (State)	
	Number	Percent	Number	Percent
1968	317,400	91	23,400	6.6
1977	480,500	82	60,800	10.0
Percent increase 1968–77		51		160.0

	ALJ		Court or remand	
	Number	Percent	Number	Percent
1968	7,900	2.3	313	0.1
1977	43,100	7.8	1,257	.2
Percent increase 1968–77		446.0		302.0

Report of the Subcommittee on Social Security of the House Committee on Ways and Means, Disability Adjudication Structure (1978) (hereinafter referred to as "Committee Report"). See also the statistics in appendix III appended hereto.

As the Committee Report noted,

"The irony of this is that many cases receive their fullest development at the hearing level, not at entry; and consequently place a burden on a step in the process intended mostly to assess due process. The ALJ's must often develop complex medical and vocational evidence, as well as determine whether statutory and regulatory standards have been properly applied by the State agency adjudicators."

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[6] The GAO's second report on this subject, not mentioned above, was entitled "The Social Security Administration Needs to Improve Its Disability Claims Process," and published in February 1978.

[7] The GAO's August 1976 report indicated that a review of the State decisions by Federal examiners found that in 50 percent of the cases there was not enough evidence in the file to decide the case.

As has been stated in a California State agency study, the initial adjudication not only is a "dehumanized paperwork" program from the claimant's standpoint but also has had "the effect of isolating and alienating the medical community from the disability evaluation process." Physicians in the community have little understanding of the provisions and requirements of the disability insurance claims, applicants are often erroneously stamped with a welfare label and physician cooperation is frequently difficult to obtain. The report further states:

"Physicians who are paid to perform consultative examinations do so in a vacuum, so to speak, with no real understanding of program requirements. Even physicians within the program itself are constantly required to make complex, highly judgmental decisions on an applicant they have never had the opportunity to observe or examine." Analyst/Medical Consultant Examination Project, a Research and Demonstration Project of the State of California Disability Evaluation Program.[8]

The lack of adequate medical evidence in decisions of the state disability determination was first documented by the General Accounting Office in August 17, 1976. Some three years later, GAO was compelled to report that the State agencies were still not following proper procedures for adequate development of medical information on disability claims. As will be set forth more fully below, the decisions of Mass. Rehab. continue to demonstrate this problem.

C. Other studies and reports

The General Accounting Office is not alone in its criticism of the state disability determination process. Rather, similar problems have consistently been articulated in a series of reports in the last two decades.

In 1960 the Harrison Subcommittee first criticized the use of stage agencies in making disability determinations. The report of the Harrison subcommittee stressed the inconsistency of state agency claims by the state agencies, together with the lack of development of those claims, the substantial error rates, and the misuse of consultative examinations. The agencies' failure to develop the information necessary to make a fair determination of disability was re-emphasized in the George Washington University Study of 1964.

Similarly, in 1969 Saad Nagi of the Mershor Center for Public Policy Research studied the state agency process and noted the development problems.[9] The Nagi study selected a number of denied claims and performed a more comprehensive development. As a result of fuller development, initial denials were changed to awards in 21 percent of the cases. The Nagi study concluded that the state agencies' failure to develop necessary information fully impacts most severely on persons disadvantaged by their I.Q. or socio-economic status, persons who have a combination of impairments, and persons who have adverse vocational factors but with less severe medical impairments.

In 1971, the Social Security Administration established a special study group to research access to the disability system by socially disadvantaged persons. The special study group found that claimants have substantial difficulty understanding Social Security's form letters and brochures, and recommended that initial determinations be redetermined automatically in all cases.

Again, in 1975, the Social Security Administration constituted a task force to review the disability process, known as the Boyd Committee Report. With respect to the initial determination process, the Boyd Committee suggested that State Agencies be assisted by district offices through an upgrading of the quality of the initial interviews and recommended that claimants have a face-to-face interview at the state agency either at the initial or at the reconsideration level. The recommendation for a face-to-face hearing was also made in the 1978 departmental task force's report entitled Proposals of the Disability Working Group.

Despite the fact that these problems have existed historically in the state agency disability determination process and that the Social Security Administration has consistently been put on notice of these problems both through its own internal studies and through other reports, there has been little significant change in the state agency process. As will be seen below, these same problems continue to exist.

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[8] Jan. 29, 1978, report of House Ways and Means Subcommittee on the disability adjudication structure, part D, "Analyst/Medical Consultant Examination Project."

[9] These problems in development were also stressed by the 1973 Administrative Conference study conducted by Robert Dixon. This was again confirmed by the Bureau of Hearings and Appeals Study of Documentation by State Agencies in 1977.

D. Functioning of Mass. Rehab.

Interviews with personnel from Mass. Rehab. have indicated that the disability determination service at Mass. Rehab. is understaffed, overworked, and more concerned with timely processing of disability applications than with the quality of decisions. It has been suggested that whereas the optimum caseload per worker is 80 cases, the average caseload within the D.D.S. at Mass. Rehab. often is in the range of 100 cases. This situation has resulted in a turnover rate of 50 percent a year in examiners and created a situation where approximately 75 percent of the examiners have experience levels of less than 2 years. Recent interviews with Mass. Rehab. personnel indicate an intensification of turnover, work pressure and dissatisfaction. It is alleged that Mass. Rehab. management has even had to undertake deliberate backlogging to alleviate pressures, and that this practice has drawn negative pressure from SSA.

The D.D.S. at Mass. Rehab. operates on the bass of production goals: (a) each week an examiner should get out 20% of pending cases; (b) no more than 5 percent of pending cases should be 70 days or older; and (c) no more than 15% of pending cases should be 45 days or older. The pressure of the production goals results in a heavy volume of case-work without careful consideration or full development of all necessary evidence. There is one doctor assigned to each of the units within D.D.S. Each doctor works an average of 20 hours per week, in which time he or she will review approximately 100 cases. The pressure is for output and, as a result, cases are denied in order to move the case along rather than to take the time to develop the case.

D.D.S. is further assisted by outside medical and psychological consultants who are sent claimants for examination. Yet many of these consultants are also motivated by heavy volume, rather than by a detailed determination. This often results in a hasty and inadequate examination by the medical consultant. Adequate instructions to the consultant are nonexistent. Mass. Rehab. apparently has developed no process with which to assure quality in their consultations or to otherwise successfully review their consultants.[10]

The problem with high turnover of staff is intensified by inadequate training of the existing staff. Training has evolved toward emphasis on regulations and processes, with insufficient emphasis on medical substance. There is minimal training with regard to the sequential evaluation process.

Interviews with D.D.S. personnel also support the conclusion (see Sections I.E. and III below) that Mass. Rehab. employees are applying incorrect and overly narrow standards of disability. For instance, as a practical matter, employees see the listed impairments (20 C.F.R. Part 404, Subpart P. Appendix I) as limiting disability claims. Similarly, in the psychiatric area, noted below as a particular problem, our interviews suggest that it is virtually impossible to have a claim approved at the D.D.S. level unless a claimant is floridly psychotic, cooperative with treatment, and unresponsive to medication, or unless the claimant is "institutional pre-release", i.e. an individual, usually with years of institutionalization, whose release is contingent upon allowance of benefits. Despite the broad language of the psychiatric listings, allowance of psychiatric claims at the initial or reconsideration stage is rare.

E. Massachusetts survey

In order to determine the application of the national findings to Massachusetts and in order to judge whether the state's disability determination service was treating claims uniformly or fairly, a detailed survey was sent to a selection of legal services workers who represent SSI claimant across the state. The survey asked the representatives to provide information concerning illustrative cases which had been denied by DDS at initial application and reconsideration and had been overturned by the administrative law judge on appeal. Advocates were asked to answer a set of ten questions for each individual case, as follows:

(1) Type of case (listing all disabilities and their nature).
(2) Level at which advocate entered: Initial application, Reconsideration, ALJ.
(3) Client description (age, education, work history and functional limitations).
(4) Records in the file (when received by the advocate) obtained by DDS.
(5) Documents which DDS knew or should have known to be available and which were later submitted by advocates or other means.
(6) Level at which documents not obtained by DDS were submitted.
(7) Rationale of DDS in evaluating, assessing and denying claim.

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[10] Mass. Rehab. may also be having difficulty in finding consultants for assistance because of problems with prompt payment. It has been alleged that at one point Mass. Rehab. owed approximately $14,000 to Lemuel Shattuck Hospital for past consultative examinations.

(8) What, in advocate's opinion, was DDS's error?

(9) On what was the ALJ's favorable decision based?

(10) In advocate's opinion, what was it that caused the ALJ to reverse DDS's determination?

The survey response included 44: case analyses. These survey responses serve as a graphic illustration of the poor quality of the disability determination service's evaluations, the lack of thoroughness, uniformity, and consistency, and the disingenuous justification for inaccurate decisions.

Responses to questions one and three give us a claimant profile. Nineteen of the claimants involved (43%) had a combination of physical and mental impairments. Twelve had physical impairments only; thirteen had psychiatric impairments unaccompanied by any organic complications.

Age, Education and Work history profile:

I. Under 18	2
II. 18-44:	
A. Limited or less education:	
1. Unskilled	9
2. Skilled	2
B. High school and/or vocational training:	
1. Unskilled	4
2. Skilled	3
III. 45-49:	
A. Limited education or less:	
1. Unskilled	2
2. Skilled	1
IV. Advanced age (over 55):	
A. Limited or less education:	
1. Unskilled	8
2. Skilled	4
B. High school and/or vocational training:	
1. Unskilled	2
2. Skilled	6

None of the 44 cases fell into the "Approaching Advanced Age" category.

45 percent of the claimants were over 55 years old, and more than half of them had limited or less education. Responses to subsequent questions indicate a chronic failure by Mass. Rehab to consider vocational factors in conjunction with the impairment.

The data in response to questions four and five revealed that in only four of the surveyed cases had Mass. Rehab. obtained all the documentation which it knew to be available. However, in the narrative portion of these four responses, advocates indicated that in some cases they were able to obtain additional medical evidence by a perceptive reading of existing evidence and an appropriate referral. In the other 40 cases, the number of reports and documents which D.D.S. had access to, but failed to obtain, ranged from one to six as follows: 1 report, 11; 2 reports, 9; 3 reports, 8; 4 reports, 5; 5 reports, 5; 6 reports, 2.

Thirty-one responses to question #8 (D.D.S.'s errors) had only five variations and the remaining thirteen responses involved different combinations of the same five themes:

Errors of D.D.S. as observed by advocates:

A. Failure to obtain available, current evidence	9
B. Considering isolated elements rather than total effect of impairments	3
C. Failure to integrate impairment and vocational factors	4
D. Failure to consider impact of psychiatric elements	11
E. Reliance on cursory or erroneous consultative examinations	4
F. A and B together	7
G. B and D together	1
H. D and E together	1
I. A and D together	4

The failure to consider the impact of psychiatric problems in a total of sixteen cases seems to indicate that this is a particular problem at Mass. Rehab. The other large problem areas presented are clearly the failure to obtain all possible evidence and the propensity to weight each functional element in isolation rather than to look at the significance of the combination of impairments. The existence of these problem areas is further emphasized in the responses to question #9 (basis of ALJ's decision):

A. Submission of more evidence and complete review of the total record	14
B. Consideration of age, education and work experience	3
C. Consideration of combined impairments	3
D. Personal appearance	2
E. A and B together	6
F. B and C together	2
G. A and C together	1
H. A, B, and C together	1
I. A and D together	12

Thus, in fourteen cases the advocates indicated that the ALJ based the favorable decision simply upon complete review of the total record. In those responses which involve other factors, including consideration of vocational factors and combined impairments, the persuasive effect of total review was asserted by representatives in all but 10 cases. The inference is that had D.D.S. merely gathered documentation available to it and conducted a thorough analysis, many of those cases might not have needed to go through an expensive and time-consuming appeal process.

The compilation of survey results summarizes only the main categories of errors. Other problems with the Massachusetts disability determination service as established by the surveys do not really fit into these compilations. The narrative responses are indicative of other consistent problems with the system:

"D.D.S. failed to consider impact of combination. D.D.S. failed to look at other system effects of disease."

"Failure to examine client's ability to find or maintain work in terms of her total life experience, i.e. age, lack of formal education or training, inability to communicate in English."

"Very cursory psychiatric consultant . . . ignored cumulative effect of all ailments . . . ignored pain . . . ignored severity of depression . . . no work on drug dependency even though it was mentioned in medical reports."

"Failure to credit consultant's conclusions regarding psychiatric condition."

"No follow-up on personal doctor contact. No attempt to seek out records except those submitted by applicant."

"This case shows the D.D.S. use of medical opinion of in-house physicians and how bad it can be. The consulting physician cited chapter and verse of the listed impairment of the client, yet D.D.S. ignored it and relied on the disability review physican opinion, which was contrary to the consulting physician's opinion."

"D.D.S. never considered a claimant's subjective testimony."

"Failed to develop obvious psychiatric component of impairment . . . Failed to obtain all records. . ."

"Failure to consider multiple functional limitations including inability to stand, walk, sit, manual dexterity. The reports from both her treating physicians were extensively documented and support disability. No weight given to personal physician or expert opinion. As usual, only report really relied upon was consult."

The survey makes quite clear that D.D.S. repeatedly commits the same errors. As set out above, the failure of state agencies to obtain evidence and consider it as a whole, and their failure to properly evaluate psychiatric elements and vocational factors have been consistently emphasized in virtually every study of the disability determination system. (See Sections (2) and (3) above). The findings of the survey substantiate these precise problems as the particular weaknesses of the disability determination service in Massachusetts. The illustrative survey is perhaps best understood, however, in actual case histories which exemplify the problems within the Massachusetts D.D.S.

II. CASE HISTORIES

A. Introduction

The extent to which claimants are adversely affected by actions of the Disability Determination Services can only be understood by an examination of actual case histories.

The persons whose "stories" are summarized herein suffered from, and were affected in various ways by, the conduct of the Disability Determination Service.

Obviously, each claimant's circumstances are, in one way or another, unique. Furthermore, a small selection of histories such as is presented here cannot come close to describing all of the obstacles imposed on a claimant by the Disability Determination Service or how such obstacles impact on the claimant.

Nevertheless, these histories do make it clear that sustantial improvements in the process must be made if individual claimants are to receive fair and lawful consideration of their claims.

B. Case history No. 1, Mrs. Alden

Mrs. Alden, who is now in her sixties, worked most of her life as a domestic and frequently worked multiple jobs and 6-day weeks in order to raise her family. As her age advanced, her ability to work lessened. At times her situation led to the excessive consumption of alcohol which caused her condition to worsen further.

On February 23, 1979, Mrs. Alden applied for disability benefits at the age of 63. Thereafter, following an initial consideration of her application, her claim was disapproved as was her request for reconsideration. Although Mrs. Alden was represented at the reconsideration level and her request for reconsideration was accompanied by a carefully prepared analysis of her condition, D.D.S. refused to reverse its earlier determination.

At the time of her application and subsequent denials, Mrs. Alden suffered from the following disabling conditions:

1. Chronic anxiety state accompanied by somatic tremors;
2. Glaucoma in both eyes;
3. Chemical diabetes melitus
4. High blood pressure
5. General psychological incapacity

Mrs. Alden's psychological incapacity was exemplified by the following diagnosis, which had been included in her case file:

1. Low-average intelligence;
2. Poor fine motor control accompanied by marked visual tremor;
3. Poor visual-motor integration and coordination;
4. Deterioration and confusion on learning new tasks;
5. Impaired sequential reasoning;
6. Inadequate performance of visual memory tasks.

These conditions and their debilitating effect were thoroughly documented in Mrs. Alden's case file and elaborated upon in the analysis submitted upon her behalf. Nevertheless, D.D.S. was unable to make the same determination as the administrative law judge who found that the claimant was not only disabled but that she was disabled as of June 1, 1975, over 3½ years prior to her initial application.

Furthermore, neither the SSA nor D.D.S. at any time responded to the carefully drawn up statement submitted in support of Mrs. Alden's claim by her advocate. Neither in the decision of D.D.S., nor in its denial notice was there a full explanation of its decision or a statement of D.D.S.'s findings. In is also clear from the record that the D.D.S. erroneously failed to take into account the disabling effect of an accumulation of separate physical and psychological impairments, and that D.D.S. failed to accord proper weight to the report of claimant's treating doctors.

C. Case history No. 2, Ms. Brown

Ms. Brown was the twenty-five year old mother of three children in 1979 when, after 18 days of hospitalization she was diagnosed as having lymphoma accompanied by pancytopenia, splenomegaly, lymphademopathy, vaginal bleeding, upper respiratory infection and bronchial asthma.

Upon discharge she began a four month treatment plan which called for weekly sessions of chemotherapy, medication to control her associated symptoms and psychological therapy to help her deal with the emotional impact of having a deadly form of cancer.[11] The chemotherapy itself caused extreme fatique, nausea, vomiting, complete loss of hair, weight loss, general weakness, intermittent pain, increased susceptibility to infection and bleeding problems.

On September 12, 1979, after her hospitalization, Ms. Brown applied for SSI. At that time, she was found to be presumptively disabled and subsequently received one quarter's benefits. Thereafter, the D.D.S. examiner made an initial determination denying Ms. Brown's claim. The disability examiner, finding that, at the time, she had had only four months of chemotherapy, denied the claim because, "she had no fever, chills or neurological symptoms," "does not meet or equal the listing as of now," and this condition "does not restrict the claimant's work related functions." When Ms. Brown asked a claims representative why her claim had been denied she was informed that she was "too young to be disabled."

In March, 1980, when Ms. Brown requested that the denial be reconsidered, D.D.S. had available records indicating that Ms. Brown had sought emergency medical assistance for "7–10 days of headache, vomiting, nose bleeds, abdominal pain and sharp chest pain" and a deepening depression. The disability examiner again ruled adversely, having found "no metastasis" and ruling that the "[i]mpairment does not present significant restrictions for basic work functions."

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[11] Approximately 25 percent of those patients with Ms. Brown's form of lymphoma undergoing a heavy chemotherapy have a normal life expectancy.

Thereafter, having suffered a relapse and learning that she was beginning the final stage of the disease, Ms. Brown requested a hearing. Further, having discovered that Ms. Brown was pregnant, Ms. Brown's physician terminated her pregnancy and peformed a tubal ligation to prevent further complications.

In preparation for the hearing, three of the treating physician's file summaries were presented to the Administrative Law Judge; the summaries indicated the rapid progression of the disease as well as the extent of the after effects of the treatment. These summaries were delivered four days after the request was sent in the mail.

None of these records had been obtained by D.D.S. contacting the treating physician, who was eager and available to discuss and clarify Ms. Brown's condition and who had initiated contacts with D.D.S. in order to provide whatever assistance she could. Unfortunately, the doctor was never put in touch with a disability examiner and was never contacted by a disability examiner. Although Ms. Brown had attempted to contact the D.D.S. in order to provide further documentation, she was essentially denied access. As a result, D.D.S. failed to adequately develop Ms. Brown's case and failed to properly investigate her residual functional capacity. It was clear that D.D.S. had denied Ms. Brown's claim because it had rigidly determined that a finding of disability is warranted only where the person's condition constitutes a listed impairment.

The Administrative Law Judge decided in Ms. Brown's favor without the further delay of a hearing on the basis of the same evidence which was available to D.D.S.

D. Case History No. 3, Mrs. Clark

Mrs. Clark filed for disability benefits on February 27, 1978 and November 11, 1979. She is 60 years old and is unable to read, write or speak English.

As of October 20, 1977 her blood pressure was 220/120 and 220/140. She also suffered from heart disease, dizzy spells, fatigue, and nervousness. One of her examining physicians reported that her hypertension was uncontrollable, her prognosis was "fair to poor" and that her medication caused weakness and dizziness.

The consulting physician to whom she was referred by D.D.S., who examined Mrs. Clark subsequent to the November application did not speak Spanish, her only language. This may have been the reason that in his report he stated that "[t]his is a medical consultation of unusual complexity". Only after plaintiff's representative intervened did D.D.S. order a psychological consultation to be conducted with the assistance of an interpreter.

The doctor who had earlier examined Mrs. Clark was asked about how D.D.S. responded to his recommendations. His response was that he had been doing these tests for 5 years, everyone expects patients to be denied disability the first time around, this is how the system keep costs down, and the decisions are appealed anyway. D.D.S. did not attempt to monitor or in any way follow-up on its consultative examination. In fact, the evidence in the record was such that a finding of disability should have been made without the need for an additional consulting examination.

D.D.S. again found Mrs. Clark not disabled at the reconsideration level. On appeal, the Administrative Law Judge found in favor of the claimant on the basis of the record and further found that her disability commenced on October 20, 1977, months before her first application for disability benefits.

E. Case History No. 4, Mr. Dolan

Mr. Dolan is a 46-year-old retarded man represented by Greater Boston Legal Services in an SSI termination case. At the time D.D.S. sought to terminate his benefits, Mr. Dolan was receiving SSI on the basis of grand mal epilepsy. The D.D.S. Disability Determination Transmittal stated, in justification of the termination decision, that, although Mr. Dolan has seizures, he did not take his medication. The transmittal also stated that Mr. Dolan "recalled dates well, uses public transportation, goes to movies. He has worked in the past as a messenger, simple maintenance work and as a kitchen helper. Evidence indicates he could return to this past customary work."

According to a psychologist's report submitted to the Administrative Law Judge by Mr. Dolan's representative, Mr. Dolan's I.Q. was 58 Full Scale, 58 Performance, and 62 Verbal. This I.Q. alone was enough to qualify him as disabled under the listings (20 CFR Part 404, Subpart P, Appendix 1, Section 12.00 et seq.). Neurophysiological data also indicated "severe organic impairment of brain functions." Screening tests for educational skills indicated 2nd to 3rd grade work recognition skills, 1st grade spelling level and 2nd grade arithmetic skills. The psychologist to whom Mr. Dolan was referred by his representative stressed in his report that Mr. Dolan had always lived with his parents and still depended upon them for meeting everyday needs such as food and shelter. The report also indicated that Mr. Dolan has never been economically productive in his vocational pursuits and that "he does not have the mental capacity to find a job, and if a job were to be found for him, he does not have the mental capability to sustain gainful employment."

A report written by the treating physician and submitted by Mr. Dolan's representative further indicated a long-standing history of grand mal epilepsy, chronic alcoholism "with resulting complications like malnutrition, electrolyte imbalance, and peripheral neuropathy. This conclusion is supported by laboratory data." The report also indicated the presence of proctitis and hemorrhoids. The treating physician indicated that he did not believe Mr. Dolan was taking his epilepsy medications regularly, and attributed irregularity of treatment and follow-up to "multiple factors like alcohol dependence, mental changes and social circumstances." He concluded that Mr. Dolan was not capable of doing any useful work and had not been capable of working for over a year (the period of time the physician had known Mr. Dolan), and that the situation was going to be protracted.

Finally, Mr. Dolan's representative offered to submit evidence that Mr. Dolan, while failing to meet the listing for statutory blindness, just fell short of this standard.

On the date of the scheduled hearing, the Administrative Law Judge ruled in Mr. Dolan's favor, after reviewing the new evidence submitted by Mr. Dolan's representative (including a psychologist's report, treating physicians' report, and certified admission and discharge record from the public school system), without opening the record for a hearing. Although the A.L.J. attributed her finding to the new evidence submitted, much of the information would have been available to the DDS had a thorough and serious evaluation been undertaken.

Documents provided to DDS by the Department of Public Welfare indicated that Mr. Dolan attended the Winthrop Public Schools until the 7th grade and had been in a "Special Class." All applications and supplemental information forms sent by DDS or SSA to Mr. Dolan were filled out and signed not by Mr. Dolan but by his mother, and even these forms were barely literate. In person, Mr. Dolan presented a bizarre appearance and had a childish and dependent manner which immediately suggested retardation and/or other mental disorder.[12] Forms filled out by Mr. Dolan's treating physician noted chronic alcoholism with evidence of liver disease. Despite all these indications of intellectual and other psychological deficiencies, Mr. Dolan was never sent for psychological testing or other intellectual or psychiatric evaluation.

The physician to whom DDS sent Mr. Dolan listed his areas of specialization as "neurology; psychiatry"; however, the examination performed was a physical RFC. A very partial mental status examination (names of presidents, dates, arithmetic, memory) was administered. Despite the fact that Mr. Dolan's mother came to the appointment with him and provided all history; despite the consulting physician's awareness that Mr. Dolan had attended special classes and could not read or write "to any extent"; despite the fact that the partial mental status examination was not entirely normal; and despite the physicians' perception that Mr. Dolan had alcohol on his breath at the time of the examination, the consulting physician did not suggest any further psychological or psychiatric work-up and limited his own comments to the physical diagnoses requested by DDS.[13]

Furthermore, DDS did not follow up on Mr. Dolan's mother's contentions that Mr. Dolan could not see, and did not pursue the question of his ability to self-administer medications, despite the obvious indications of mental difficulties and alcoholism, and despite DDS's eventual reliance on Mr. Dolan's failure to take his medications in justifying termination of benefits.

The DDS also failed to obtain an accurate and useful work history. The history presented by Mr. Dolan's mother to DDS indicated that Mr. Dolan had last worked regularly, at a menial physical job, ten years earlier. Other evidence in the record seemed to suggest the possibility of more recent work, eight years earlier; this work was also menial and apparently irregular. The Disability Determination Transmittal which justified termination of benefits simply concluded that "evidence indicates he could return to this past customary work" but did not cite any evidence for this conclusion.

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[12] The SSA (local office) interview form did not indicate anything unusual about Mr. Dolan's appearance, and since DDS itself did not conduct a face-to-face interview, DDS personnel did not have the opportunity to perceive Mr. Dolan's abnormality.

[13] The physician also noted the Mr. Dolan was edentulous.

In the case just described, DDS's failure to develop by consultative examinations or otherwise, conditions which were not alleged by the claimant but of which there was clear evidence in the file was aggravated by a number of elements. These elements included a lack of face-to-face interview which would have made recognition of the claimant's multiple impairments more obvious and inadequate evaluation by a consulting physician who failed to explore, or recommend exploration of, conditions suggested by his own observations. DDS's failure to assist the claimant in development of his case was particularly negligent in view of suggestions in DDS's own file that even Mr. Dolan's family, with whom he lived and on whose cooperation he was dependent, "all appear mentally limited." The brief, self-serving and unsubstantiated Disability Determination Transmittal furnished by DDS underlines the inadequate development of the case.

F. Case history No. 5, Ms. Hernandez

Ms. Hernandez is a forty year old Puerto Rican woman represented by Greater Boston Legal Services in an initial claim for SSI benefits. Her claim was based entirely on psychiatric disability. She grew up and was educated in rural Puerto Rico, and had her first "nervous breakdown," for which she was hospitalized, when she was fifteen years old. She graduated from high school, and worked as a stitcher for one year, after which she was laid off. She moved to the United States in her mid-twenties, with her husband. In the United States, she again worked as a stitcher for a period of a year, and stopped work when she was hospitalized for a psychiatric episode following the death of her child. The two isolated years as a stitcher comprise her entire work history.

Hospital records and medical reports obtained by DDS indicated at least six hospitalizations in the five years preceding her disability hearing and at least five hospitalizations in the four years preceding her initial application. A treating psychiatrist's report obtained by DDS indicated hospitalizations were more frequent, on the order of two to three yearly. The records indicated a pattern of psychotic episodes characterized by auditory hallucinations and extreme behavior such as smashing windows, undressing frequently in front of others, talking to people not present in the room and playing with dolls. These records also indicated consistent treatment with major anti-psychotic medications, and varying but severe diagnoses over the relevant period of time ("manic depressive illness", "chronic schizophrenia", and "severe schizo-affective disorder").

The report submitted to DDS by the consulting psychiatrist to whom DDS sent Ms. Hernandez confirmed Ms. Hernandez' inability to do sustained work. The consulting psychiatrist noted Ms. Hernandez' inability to travel beyond her immediate surrounding without becoming lost, and concluded, on the basis of her history and clinical manifestations, that she "could get overwhelmed quite easily" in a regular job. He stated also that she "could easily decompensate under the stress of a regular job."

The report of Ms. Hernandez' treating psychiatrist obtained by DDS a few months after the consultative examination indicated that for the year period he had treated Ms. Hernandez, she had had "various psychiatric hospitalizations characterized with inappropriate behavior, auditory hallucinations and euphoria and inappropriate affect. He indicated that her condition "has not been very stable" but that it had been possible to avoid re-hospitalization at the time of the report. He noted continuing medication and group therapy sessions. In response to the DDS questionnaire, the treating psychiatrist noted no current evidence of inappropriate behavior but continuing signs and symptoms of depression. His continuing diagnosis was "manic depressive illness." The treating psychiatrist was not asked about Ms. Hernandez' ability to work and was not asked to fill out an RFC form.

Shortly after the submission of the treating psychiatrist's report, DDS denied Ms. Hernandez' claim on reconsideration. The rationale portion of the Disability Determination Transmittal sheet stated that "(the treating psychiatrist's report) notes that she is currently in remission without evidence of psychosis and is currently able to care for herself and carry out routine activities as shopping and housework. Based on (the treating psychiatrist's) report this impairment is felt to be slight and therefore not disabling." This description of the psychiatrist's report is inaccurate and distorted. As just noted, the report had actually indicated a serious and continuing psychotic condition. Although the treating psychiatrist had not noted current "inappropiate behavior," he had indicated the instability of Ms. Hernandez' condition and the frequency of recent past hospitalizations. He had not used the term "in remission." The DDS examiner denying benefits isolated from the treating psychiatrist's report the information that Ms. Hernandez was in fact doing household chores and shopping, but did not address the continuing serious disease and did not in any way justify the conclusion that Ms. Hernandez could perform substantial gainful activity because she could do her daily chores.

Further psychiatric letters submitted by Ms. Hernandez' representative in fact stressed that Ms. Hernandex could do her daily chores and maintain daily life outside a hospital setting "only with careful social and medical follow up (and with the care of) a strong family network who provide great help in supplying the patient's basic needs." Letters form two treating psychiatrists directly addressed each of the elements of a listed psychotic impairment (20 CFR Section 404, Subpart P, Appendix 1, 12.00 et seq.), noted side effects of medications which further sedated her, and indicated explicitly the risk of Ms. Hernandez' developing a full-blow psychosis if subjected to the stress of sustained work.

The DDS's error in Ms. Hernandez' case was not in failing to pursue the appropriate impairment but in ignoring the evidence which it did amass. The DDS rationale for denial of benefits misstated the diagnostic information compiled by DDS. Furthermore, DDS appeared to rely on the assumption that the claimant had to be exhibiting current florid psychosis and/or current hospitalization to prove a severe impairment. DDS also ignored statements by its own consulting psychiatrist concerning the risk of decompensation under normal work stress.

III. RECOMMENDATIONS

Since the focus of this report is the Massachusetts' disability determination service provided through the Massachusetts Rehabilitation Commission, the criticism and recommendations of this report are aimed at deficiencies of that agency. As discussed in Part I, the problems described here as problems of the Massachusetts D.D.S. seem to be common to state disability determination agencies nationally and have been the subject of numerous recommendations for correcting the entire disability determination system of the Social Security Administration. Particularly in the areas of personnel policies (caseload, staffing, salaries, etc.), standards for case development, and quality assurance, solutions will have to be part of an improvement of the process on a national scale. Nevertheless, in looking at the functioning of the Massachusetts D.D.S., this group has formulated certain recommendations.

A. *Quality of case development*

As the discussion above indicates, the Massachusetts D.D.S. is not doing a "quality" job of case development. That is, it is not coming to grips with the cases before it and engaging in a thorough "digging for facts" which will determine whether a claimant is truly disabled. In addition to the recommendations in later sections, general recommendations can be made concerning case development:

1. Disability Examiners need to be furnished with more defined standards concerning the development of a case. (See sections I.B, I.C., I.E., II.C., and II.E. above). These standards should concern not just documentation, i.e. defense of a decision which has been made, but also steps necessary for a complete investigation (See B et seq.) This recommendation is consistent with the recommendations of the 10/9/79 GAO report, pp. 29-30, that the Commissioner of SSA develop and implement, in close cooperation with state agencies, "clear, concise, and attainable documentation guidelines and standards necessary for making an acceptable disability decision "and that the commissioner of SSA conduct a national elapsed time study to "identify the best developmental practices used by state agencies . . . ."

2. Disibility Examiners should develop information not just about impairments which a claimant alleges but also about unalleged impairments of which there are indications in the records. (See Sections I.B., I.C., I.E., and II.E. above). Case law has consistently held the Social Security Administration responsible for assisting disabled claimants in developing their disability claims. See, for example, *Fessler* v. *Matthews* 417F. Supp. 570 (S.D.N.Y. 1976), *Rasa* v. *Weinberger* 381F Supp. 377 (E.D.N.Y. 1974). Disability claimants, particularly in psychiatric cases, do not always know or understand all aspects of their disabilities and can often articulate at best the rough outline of their disabilities. This reality was recognized in the January 29, 1978 House Ways and Means Subcommittee on Social Security report on the Disability Adjudication Structure. Part D of that report, "Analyst/Medical Consultant Examination Project" discusses the experience of the California D.D.S. with a demonstration project which allowed for face-to-face contact between the disability examiner and certain claimants. The subcommittee report (at p. 53) explains that when the only face-to-face contact is with the SSA district office claims representative "the information that is obtained from the claimant/claims representative interview is often deficient, in that the interviewer is not trained to elicit essential data relevant to physical or mental functioning nor to detect subtle signs and symp-

toms of the impairment" (emphasis added). It is not assumed that the claimant himself or herself is capable of alleging all relevant items.

3. Disability Examiners must apply the disability standard contained in the Social Security Act regulations and case law. (See Section II.C above). Currently examiners often seem to apply a standard which is narrower and which does not allow for the full range of disabilities allowed by the law, regulations and case law. D.D.S. should not simply be determining whether the applicant's condition constitutes a listed impairment. In particular, examiners must:

(a) be fully aware that disability is not limited to conditions which meet or equal the listings but can include, for instance, combinations of impairments. Our interviews with D.D.S. personnel suggest that disability examiners currently see the listing as limiting disability claims as a practical matter if not as a matter of law. (See Sections I.A, I.D, and I.E above).

(b) be fully aware of the need to exercise judgment and discretion concerning residual functional capacity before applying the grid (step 5 of the sequential evaluation process) to the individual claimant. (See Section I.D. above). The grid governs only in cases where the claimant has already been determined to fit exactly within the grid's categories, that is, where the claimant has been judged able to perform the full range of sedentary work, or light work, etc. and where the claimant's age, education and work experience exactly fit the grid's specifications. Therefore, examiners must look at each case individually and must be aware that they still have full discretion to determine a person disabled on the basis of all available facts. If an examiner determines that a claimant is disabled, the grid may not apply. Our interviews indicate that examiners see the "grid" as removing their previously broad discretion. (See Section I.D. above).

(c) be fully aware of the appropriateness of considering subjective factors. (See Sections I.C. and I.E. above). This necessity is particulary important in cases involving, for instance, back pain or psychiatric impairments, where the objective clinical data may not be the final word on the claimant's true ability or inability to work. These cases are often given little consideration by the D.D.S. (see discussion of psychological impairments below).

4. Disability examiners should be giving appropriate weight to the report of treating physicians and should be using consultative examinations as a source of otherwise unavailable information or as a means of clarifying confusion in existing records rather than as source of alternative and often less pro-claimant conclusions. (See Sections I.B., I.C., I.E., II.B., II.C., II.D., and II.E. above). Disability examiners should be expected to follow up vigorously treating physicians' initial reports and to update their files, as a case progresses, with the most recent medical information from treating physicians.

5. Disability examiners should give weight to opinion evidence when such evidence is offered by appropriate experts, for instance, treating physicians and consultative physicians. (See Sections I.E., II B., II.C., II.D, and II.F.)

6. Disability examiners should handle investigation of residual functional capacity in a more detailed and thorough way. (see Sections I.C., II.C., II.E., and II.F. above). For instance, in cases where it is necessary for the examiner to list specific jobs a claimant can perform, the examiner rarely asks the claimant and/or the appropriate physicians questions which are specific enough to allow conclusions concerning the specific RFC a claimant must have in order to perform the jobs listed by the examiner.

7. The initial determination and reconsideration should involve face-to-face interviews between the disability examiner and the claimant. (See Sections II.E. and II.F. above). Any claim concerning the fairness and competence of the initial and reconsideration-level disability determinations is compromised by the absence of such interviews. In describing the California Analyst-Medical Consultant Examination (AMCE) Project (Report on Disability Adjudication Structure, supra), the House Ways and Means Committee, Subcommittee on Social Security stressed the importance of personal contact between claimants and individuals trained to elicit complete data. "This entire (present) process fails to recognize or incorporate some very basic principles that have long been accepted by other professions involved in evaluating a person's capacity to work. For example, it is generally accepted that disability affects each person uniquely and that generalizations regarding the effect of a particular impairment upon the ability to function cannot be made from one case to another. It is also generally accepted that counselling and one-to-one interaction is essential to professional evaluation for disability eligibility or rehabilitation services in order to identify the unique characteristics and factors that are so important in

understanding and accurately assessing an individual's ability to function . . ." (Report, p. 53).[14]

The subcommittee report describes the success of the AMCE Project. The project was not only more humane than the system generally in use nationally but also more efficient and cost-effective. Because face-to-face interviews allow for more accurate assessment of a claimant's impairments and clearer understanding of a claimant's allegations, fewer consultative examinations have been necessary and those conducted have been more clearly focused (Report, pp. 62, 63).

Furthermore, requests for reconsideration have been reduced, as have appeals. It was the finding of the subcommittee that appeals are reduced "because claimants gain a better understanding of the disability programs and are evaluated under a system that affords them due process in a very concrete sense . . ." (Report, p. 55).

Whether or not the face-to-face interview is part of a project similar to the AMCE project,[15] the face-to-face interview appears to be a necessary part of a competent and professional disability evaluation. It will be necessary, however, to structure such interviews in such a way that they safeguard claimants' rights. Claimants must have adequate notice of the purposes for which such interview can be used; attention must be given to the appropriate role for claimants' representatives; and claimants must be protected against any undue or subtle influence toward withdrawing cases or abandoning appeal rights. Face-to-face interviews must not become part of a system in which the record is closed prematurely before an opportunity for a proper hearing.

B. Accountability of disability examiners

Advocates have complained that written documentation of initial and reconsideration level determinations is often sketchy and inadequate (see Sections I.B., II.B., II.E., and II.F.). Examiners should be required to provide greater written justification for their decisions than is current practice. Written justification should include at a minimum:

1. Reasons for discounting any impairments alleged by claimant;
2. Reasons for discounting specific physicians' opinions;
3. Documentation for opinions of the examiner, such as statement of any job a claimant is alleged capable of performing, and justification for any allegation that the claimant can perform such a job.

Further, denial notices at the initial and reconsideration stages should provide claimants with specific reasons for the conclusion that the claimants are not disabled (see Sections I.C. and II. B. above). The notices should be sufficiently clear and explicit to permit claimants or their representatives to determine what allegations they will have to disapprove at the next stage of the decision-making process and what, if any, information was not available to the D.D.S. examiner.

It must be stressed that any such accountability requirements can be a favorable contribution to the disability determination process only if examiners are given adequate time to develop cases and to provide this additional documentation.

In addition to written accountability for decisions, disability examiners should also be made more responsible to claimants while handling cases (See Sections I.C. and II.C. above).

In keeping with the previous recommendation for face-to-face interviews with disability examiners, D.D.S. workers should be accessible to claimants, their representatives and their physicians during case development. Claimants should be routinely notified of the names of the workers handling their cases. To allow for adequate communication with claimants, D.D.S. should be more accountable for the physical location of files. In addition to being accessible to claimants, examiners should be contacting claimants, doctors or other appropriate persons when questions arise concerning such aspects of the case as work history, education, RFC, etc., or where these aspects need clarification. If this aspect of accountability is to be taken seriously, D.D.S. will have to provide bilingual workers where necessary.

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[14] The subcommittee explains that Congress's original intention, in establishing state vocational rehabilitation agencies as disability determination services, was to make use of the expertise of these agencies in evaluating disability; that this intention was undermined by the use of new personnel in separate disability programs rather than experienced rehabilitation counsellors; and that the disability evaluation program evolved into a "paperwork program" in which "interpersonal contact with the claimant, considered superfluous to the program's purposes, was deemphasized and, eventually, virtually eliminated" (Report at p. 52).

[15] The AMCE project involved pairing of a disability examiner with a D.D.S. staff physician who performs consultative examinations in his capacity as private physician and is later available for assistance with case development.

C. Training

Both disability examiners and interviewed claimant advocates see a need for more extensive and/or better training of examiners (see Section I.D.). Training of examiners should emphasize both more substantial understanding of the medical and vocational material with which examiners are dealing, for example, residual functional capacity, pain and psychiatric impairments, and an expanded understanding of the scope of the SSA statute, regulations and case law. Training on the evaluation process should emphasize all items discussed in Section III.A. above. While the training of examiners should be primarily medical/vocational and not legal in nature, examiners need to have at a minimum a legal context which will allow them to understand the full scope of their duties as examiners.[16]

D. Psychiatric evaluations

In evaluation of psychiatric disability, many of the D.D.S.'s problems are most pronounced (see Sections I.E., I.D., II.B., II.E., and II.F. above.) As set out above, it is virtually impossible to have a psychiatric claim approved unless the individual is overtly psychotic and meets a much narrower standard than the law imposes." (See II.F. above).

1. Evaluation by disability examiners.—

(a) Disability examiners should be instructed to give credence not just to "floridly psychotic" claimants but to any claimant whose impairment meets the broad criteria of the listings (20 CFR Part 404, Subpart P, Appendix 1, Section 12.00 et seq.) or whose impairment in fact renders the claimant unable to perform substantial gainful employment. This means that examiners must credit the full range of disabilities: psychotic, neurotic, personality disorders, retardation, organic brain syndrome, etc. Emphasis should be placed on interference with work functioning, not just on psychiatric pathology and examiners must look carefully at cases in which work pressure itself is likely to cause decompensation. (See Section II.F. above).

(b) Examiners must look more closely at the way psychiatric disability interacts with physiological disabilities and with the effect of medications.

(c) Examiners must elicit psychological/psychiatric information (from treating physicians, consultative examinations, etc.) where there is mixed psychiatric/physiological disability or where there is any evidence of a psychological problem.

2. Use of consultative examinations.—

(a) Examiners should consider the importance of psychological, and not merely psychiatric, evidence (see Section II.B. above.) Psychological evidence would include neurological testing and other such tests.

(b) In some cases, the present one-session consultative examination may be inadequate. The type and length of consultative examinations should be geared to the nature of the claimant's psychiatric history. For instance, a claimant not in treatment and without any source of psychiatric information other than the consultative psychiatrist or psychologist may need a longer and more extensive psychiatric work-up than a person with a more documented history, and such a work-up may need to be extended over more than one session.

(c) As discussed in Section F below, written instructions to consulting doctors must be altered so that:

(1) D.D.S. eliminates any instruction which limits the doctor's response to less than the doctor's complete medical conclusions about the patient's condition and about the issues being considered by the D.D.S. (see Sections I.B. and I.C. above.). For example, a current DDS instruction to doctors requires omission of any reference to the claimant's ability or inability to work. This instruction should be deleted. Opinions regarding ability to work are relevant in any psychiatric evaluation and are at the core of the disability evaluation.

(2) Instructions should explain to consulting doctors the full range of psychiatric conditions which may be considered to be disabling. Although doctors are presently provided with a copy of the disability regulations, it cannot be assumed that they have any familiarity or ease with the language of the regulations. Furthermore, our own discussions with doctors who serve as consulting psychiatrists and physicians indicate that doctors, like disability examiners, seem to believe that conditions must meet the listings in order to be considered psychiatric disabilities. A more comprehensive explanation of the possible range of disabilities must be provided. Instructions should explain that impairments do not need to reach the level of psychosis to be considered disabling, but rather neurosis and other nonpsychotic impairments may qualify as well.

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[16] For example, the need to make professional, individual determinations which go beyond the listings.

(d) More specific questions should be posed to consulting psychiatrists and psychologists to elicit complete reports. At minimum, the following areas should be included:

(1) More specific questions regarding residual functional capacity;

(2) More specific questions concerning each element of the listings and, where necessary to make the elements less vague and easier to address, questions explaining those elements more discretely. For instance, "ability to relate to others" and "constriction of interests," both of which are elements of the listings (20 CFR Part 404, Subpart P, Appendix 1, Section 12.00 *et seq.*), are vague; a doctor might not know what behaviors to include in addressing these elements. More specific directions could, for example, include questions about whether a particular claimant has more constricted interests than he or she previously maintained.[17]

(e) In addition to the considerations made above, the general discussion of consultative examinations at Section F. below is applicable to psychiatric examinations as well.

F. Quality of consultative examinations

The concern which has been expressed about the D.D.S.'s use of consultative examinations has emphasized both the quality of the physicians used for consultative examinations and the quality of the reports submitted by consulting doctors (see Sections I.B., I.C., and II.E. above). The October 9, 1979, GAO Report on Controls Over Medical Examinations Necessary for the Social Security Administration to Better Determine Disability states that SSA's own surveys suggest that evidence from treating sources was not pursued adequately, consultative examinations were purchased unnecessarily, and consultative examination reports were often inadequate for State Agency use (p. 7). The GAO report indicates that, "when possible, all medical evidence should be obtained from existing sources such as treating physicians or institutions, with C.E.s used when there is a specific inadequacy or conflict in the existing evidence." (pp. 5–6). Although the GAO report is more concerned with the fiscal and management considerations than with optimum service to claimants, these particular conclusions are consistent with the problems previously described.

In addition to those areas discussed above in reference to psychiatric evaluations, D.D.S. should address several additional aspects of their use of consultative examinations:

1. Better training of consulting physicians and psychologists. Consulting doctors should be trained in the disability regulations, in report writing, and in D.D.S.'s expectations concerning thoroughness of examinations. Such training should be mandatory for participation in the consultative examination program. Training on the regulations should convey to doctors that the "listings" are not minimum criteria for establishing disability but rather are only one means of establishing disability.
2. D.D.S. should develop a method for monitoring the work of consulting doctors, particularly the (a) adequacy of the reports submitted and (b) thoroughness of the examination. D.D.S. should convey to consulting doctors the need to spend adequate time with the claimant and should demand thorough, professional work. In view of the many complaints claimants have made to their representatives about consulting physicians, D.D.S. should establish a mechanism to monitor claimant complaints concerning physician rudeness, amount of time spent or lack of thoroughness, and other problems encountered by claimants in the consultative examination process.
3. Instructions to consulting physicians should be modified to allow for opinion evidence, and such evidence should be given full consideration by D.D.S.
4. As part of its monitoring of consulting physicians' work, D.D.S. should be informing doctors of any noted deficiencies.
5. D.D.S. should pay at a rate high enough to attract highly competent consulting doctors. D.D.S. should pay for all time necessary to ensure a high-quality evaluation, including time spent reviewing a claimant's history and writing thorough, comprehensive reports. Consulting doctors and DDS personnel we have interviewed indicate that both rate of pay and amount of time paid for are inadequate.
6. D.D.S. should better utilize medical advisors who are experts in particular specialized areas applicable to claimants' impairments.
7. Where possible, a full and accurate medical history should be submitted to doctors in advance of the consultative examination. In instances of psychiatric impairment, a medical, as well as psychiatric, history should be submitted. Our interviews

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[17] It would be important to design these questions as illustrative so as not to provide the impression that other kinds of impairments, for instance constriction of interests in comparison with other people, would not also be appropriate to a discussion of that particular element.

suggest that inadequate and inaccurate histories are detracting from the quality of doctors' reports.

8. D.D.S. must address the problem of consultants who do not speak the language of the claimant. D.D.S. should recruit and use bilingual consultants where needed.

9. Before ordering consultative examinations, D.D.S. should ascertain that the information sought is not available from the treating physician. D.D.S. should not be using the consultative examination as a source of a different view of the case when information available from the treating source is complete and consistent.

10. To encourage cost-effective, high quality consultative examinations, D.D.S. should explore the possibility of contracting with community health clinics and health maintenance organizations rather than solely with doctors in private practice.

F. Personnel

The quality of the disability determination is compromised by lack of staff, staff turnovers, caseload, and pressure for "productivity" at the expense of quality (see Sections I.D. and II.B. above). There are also suggestions (see the 10/9/79 GAO Report, p. 17) that the D.D.S.'s work is conducted in an atmosphere of intimidation. The D.D.S. must address these personnel and staffing problems if the quality of the disability determinations is to be improved. Caseloads of staff doctors and psychiatrists, who were responsible for making all final disability determinations, do not allow for serious or thorough review of cases. Further, in formulating standards of productivity, D.D.S. must set time and accuracy goals which are "realistic, comprehensive, and compatible" (GAO Report, p. 290.) D.D.S. should discontinue goals based on a percentage of caseload since such goals simply tend to penalize workers with larger caseloads.

IV. CONCLUSION

The Disability Determination Service as operated by the Massachusetts Rehabilitation Service is costly in terms of its demonstrable inability to perform its functions and in human terms. This report has noted the existing problems in D.D.S. and sets out a detailed list of recommendations designed to establish a fair, efficient, and compassionate system. It is our hope that the problems that have historically plagued D.D.S., as noted in this report and as consistently noted in prior studies, can finally be resolved through the adoption of our proposed changes. Implementation of these proposals is in the interest of fair administration of the disability system and sound management policy.

APPENDIX I. CONTRACT BETWEEN THE SECRETARY OF HEALTH AND HUMAN SERVICES AND THE MASSACHUSETTS REHABILITATION COMMISSION

MODIFICATION NO. 1 TO THE SECTION 221 AGREEMENT BETWEEN THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE AND THE STATE OF MASSACHUSETTS TO CARRY OUT THE PROVISIONS OF THE SOCIAL SECURITY ACT, AS AMENDED

Pursuant to the provisions of Part I of the agreement entered into under Section 221 of the Social Security Act on June 27, 1966, and as supplemented on June 12, 1970, between the Secretary of Health, Education, and Welfare and the Massachusetts Rehabilitation Commission, the State agency acting on behalf of the State of Massachusetts, hereby agree to the following modification in the said agreement.

The purpose of this modification is to obtain the assistance of the State under Section 1633 in the administration of Title XVI of the Social Security Act, as amended, and to facilitate administration under Title II.

In any respects not inconsistent with the modification, the provisions of the foregoing Section 221 agreement shall apply to claims under Title XVI by individuals within the State.

The affected subpart of Section A "Definitions" is amended to read as follows:

1. The term "disability" means "disability" or "blindness" as defined in Section 216(i) and 223 of Title II or Section 1614(a) (2) and (3) of Title XVI of the Social Security Act, as amended.

The affected subparts of Section B "Administration" are amended to read as follows:

2.(c) Any case in which it is clear and uncontradicted that the date of onset of the applicant's alleged disability is more than one year after (i) the last day of the period prescribed in Section 202(d)(6) or 202(e)(5) or 202(f)(6) of the Act, as appropriate, or (ii) the date he last met the requirements of Section 216(i)(3) or Section 223(c)(1) of the Act, as appropriate, or the alleged onset of his disability is due to traumatic injury which occurred after the date he last met the requirements of such section;

2.(d) Any case in which an applicant who was determined not to be under a disability and (i) as to whom the period described in Section 202(d)(6) or 202(e)(5) or 202(f)(6) of the Act, as appropriate, had expired on or prior to the date of such determination, or (ii) who at no time after the date of such determination met the requirements of Section 216(i)(3) of the Act or Section 223(c)(1) of the Act, as appropriate, files a new application;

2.(e) Any case based on an application by an applicant who had previously filed a valid request for a hearing before an administrative law judge of the Social Security Administration, but the final decision of the Secretary on the disability application on which hearing was requested was not made when the subsequent application was filed;

2.(f) Any case that falls within the jurisdiction of the Bureau of Hearings and Appeals;

2.(g) Any case in (a) of Paragraph 1 of this Part, with respect to which it is mutually agreed by the State agency and the Secretary that after consideration of the total number of pending and prospective applications in the State, the determination with respect to disability in such case can be made more expeditiously by the Secretary.

2.(h) Any case in which the issue to be resolved in the determination of disability is solely whether or not the individual is or was engaging in substantial gainful activity as described in Section 223(d)(4).

2.(i) Any case to which a prior Title XVI determination is applicable.

3. In making determinations of disability, the State agency will apply the term "disability" (as defined in Part A of this agreement) in conformity with Sections 216(i) and 223 of Title II or Section 1614(a) (2) and (3) of Title XVI of the Act, the regulations issued pursuant thereto, and such standards as may be promulgated by the Secretary.

6. Each determination of disability will be certified by the State agency to the Secretary on such form or forms as may be provided by the Secretary. The State agency will also furnish the Secretary with the evidence considered in making its determination of disability in individual cases. Any such evidence forwarded to the Secretary by the State agency will be returned upon request. Except as provided in subsections (c) and (d) of Section 221 of the Social Security Act, any determination of disability made by the State agency shall be the determination of the Secretary for the purposes of Title II of the Act. (For purposes of Title XVI of the Act see B.8.) The State agency shall not, however, be a party to or assume any responsibility for defending any determination made by the Secretary pursuant to Title II and Title XVI of the Act. For Title II determinations notification to the individual of the determination of disability will be made by the Secretary at the same time such individual is notified whether his insurance rights under Title II of the Act are preserved on account of his disability or whether he is entitled to a benefit under Title II of the Act.

8. Subject to the provisions of paragraph a. of this Part, the State agency, upon request by the Secretary, will make determinations of disability or blindness, or render such other assistance as may be mutually agreed upon, with respect to individuals in the State in cases arising under the several sections of Title XVI. All State agency determinations will be determinations of the Secretary unless the Secretary reviews and revises the State agency determination. With respect to such review and revisions of determinations, the Secretary will maintain appropriate liaison and consultation with State agencies.

a. There may be excluded from the cases arising under the several sections of Title XVI.

(1) Any case to which a prior Title II determination is applicable.

(2) Any case in which the issue to be resolved in the determination of disability is solely whether or not the individual is or was engaging in substantial gainful activity.

(3) Any case of obvious and clear-cut disability where there is no reasonable possibility that a contrary result could be reached.

(4) Any case that falls within the jurisdiction of the Bureau of Hearings and Appeals.

(5) In the absence of a specific request by the Secretary, any class of case requiring a redetermination involving a previous finding of disability or blindness as defined in an appropriate State plan in effect for the month of October 1972 under either Title X or XIV, or XVI and for which aid or assistance was granted for December 1973.

(6) Any other case or class of cases where it is mutually agreed by the State agency and the Secretary that the determination with respect to disability can be made more expeditiously by the Secretary.

b. There shall be removed from exclusion in a. above any case where it is mutually agreed by the State agency and the Secretary that the determination with respect to disability in such case can be made more expeditiously by the State agency.

c. At the request of the Secretary, the State agency will decide whether an individual is presumptively disabled for payment of benefits under Section 1631(a)(4)(B).

The effected Subpart D "Organization" is amended to read as follows:

4. Upon request of the Secretary, personnel employed or utilized by the State agency in carrying out the provisions of this agreement will be made available to attend such meetings or conferences either within or outside the State as may be sponsored by the Secretary for furthering the purposes of this agreement except as prohibited by State law.

Subpart E "Medical and Other Examinations or Services" is amended to read as follows:

1. In making arrangements for medical or other examinations or services necessary to make determinations of disability, the State agency will use the same rates of payment as it uses to purchase the same service in the State program it administers. In making such arrangements, the State agency will not bind itself to pay any fee in excess of the amount that would be paid by the regular State program to the same medical source for the same service.

2. Where a service is not used in the regular program, the State agency will not bind itself to pay any fee or cost for such service which is in excess of the highest rate paid by Federal or State agencies in the State for the same or a similar type of service.

Subpart G "Fiscal" is amended to read as follows:

2. The State agency will submit estimates of anticipated costs for such periods, at such times, and in such manner as may be requested by the Secretary. After considering all pertinent information, the Secretary will determine the amount of funds that are necessary for the State agency to administer this agreement for a particular period and that are available to keep within the limits of Federal funds allocated to carry out the purposes of the Act. The Secretary will notify the State agency the amount which will be certified for payment to it, or made available to it, for such period. The State agency will not incur or make expenditures for such period which will exceed the amount the Secretary certifies or makes available for such period unless in advance of making or incurring such expenditures the State agency obtains approval of the Secretary for such expenditures.

This modification shall be effective as of June 28, 1973. Approved for the State of Massachusetts this 25th day of June, 1973.

AGREEMENT

(To carry out provisions of Section 221 of the Social Security Act.)

The Secretary of Health, Education, and Welfare, hereinafter referred to as the Secretary, and Massachusetts Rehabilitation Commission hereinafter referred to as "the State agency", acting on behalf of the State of Massachusetts, for the purpose of carrying out the provisions of the Social Security Act, as amended, hereinafter referred to as "the Act", relative to the making of determinations of disability by State agencies on behalf of the Secretary, hereby agree to the following.

A. Definitions

For purposes of this agreement—

1. The term "disability" means "disability" as defined in sections 216(i) and 223 of the Social Security Act, as amended.

2. The term "determination of disability" includes one or more of the following determinations: (a) whether or not an individual is under a disability; (b) the date as of which the individual's disability began; and (c) the date as of which the individual's disability ceased.

3. The term "Managing Trustee" means the Federal official designated in the Social Security Act, and directed by such Act to pay from the Trust Funds (established by section 201 therof) such monies as may be certified by the Secretary to him for payment.

4. The term "Secretary" means the Secretary of Health, Education, and Welfare or his delegate.

5. The term "necessary cost" shall include indirect as well as direct costs.

B. Administration

1. Subject to the provisions of paragraph 2 of this Part, the State agency, upon request by the Secretary, will make determinations of disability with respect to individuals in the State in the following classes of cases arising under Title II of the Act:

(a) Cases arising under the several sections of Title II calling for determinations of disability.

(b) Any case specifically excluded from the class of cases referred to in (a) above in which the individual has submitted evidence indicating probability of the existence of a disability or of the continuation of a previously determined disability, but the Secretary finds from all the circumstances of the case that medical or other consultation is warranted in order to make a proper initial or current determination of disability and that such consultation can be accomplished more expeditiously and effectively by the State agency.

2. There shall be excluded from the classes of cases referred to in paragraph 1(a):

(a) Any case in which the individual has completed 10 years of service in the railroad industry as that term is defined in section 2(f) of the Railroad Retirement Act of 1937, as amended, or has been awarded an annuity under such act;

(b) Any case in which an individual, determined to be under a disability as defined in Section 216(i) of the Act, files an application for disability insurance benefits under the Act, but only insofar as the case requires a determination that such disability has (or has not) continued up to and including the effective date of his application for disability insurance benefits;

(c) Any case in which it is clear and uncontradicted that the date of onset of the applicant's alleged disability is more than one year after the date he last met the requirements of Section 216(i)(3) or Section 223(c)(1), as appropriate, of the Act, or the alleged onset his disability is due to traumatic injury which occurred after the date he last met the requirements of such section;

(d) Any case in which an applicant who was determined not to be under a disability and who at no time after the date of such determination met the requirements of Section 216(i)(3) or Section 223(c)(1), as appropriate, of the Act, files a new application;

(e) Any case based on an application by an applicant who had previously filed a valid request for a hearing before a hearing examiner of the Social Security Administration, but the final decision of the Secretary on the disability application on which hearing was requested was not made when the subsequent application was filed;

(f) At the request of the State agency, any case in (a) of paragraph 1 of this Part, with respect to which it is mutually agreed by the State agency and the Secretary that in view of the total number of applications pending in the State agency on the date the request is made, the determination with respect to disability in such case can be made more expeditiously by the Secretary.

3. In making determinations of disability, the State agency will apply the term "disability" (as defined in Part A of this agreement) in conformity with Sections 216(i) and 223 of the Act, the regulations issued pursuant thereto, and such standards as may be promulgated by the Secretary.

4. The Secretary shall, if he finds necessary, promulgate standards, with respect to determinations of disability, to insure: (a) the prompt and orderly processing of requests for such determinations, (b) equality in the treatment of individuals within the State, and (c) equality in the treatment of such individuals with the treatment accorded individuals in other States with which similar agreements have been entered into by the Secretary. If such standards are promulgated, the State agency will adopt such policies and procedures as may be necessary to conform to such standards so that the provisions of (a), (b) and, insofar as practicable, the provisions of (c) of this paragraph, are effectuated.

5. In any case in which the State agency is requested to make a determination of disability, the Secretary will furnish to the State agency any pertinent evidence he may have relative to the individual. The State agency will, in accordance with such standards as may be promulgated by the Secretary, secure from or through the individual or from other sources such additional medical or other evidence as the State agency considers necessary to enable it to make a determination of disability.

6. Each determination of disability will be certified by the State agency to the Secretary on such form or forms as may be provided by the Secretary. The State agency will also furnish the Secretary with the evidence considered in making its determination of disability in individual cases. Any such evidence forwarded to the Secretary by the State agency will be returned upon request. Except as provided in subsections (c) and (d) of Section 221 of the Social Security Act, any determination of

disability made by the State agency shall be the determination of the Secretary for the purposes of Title II of the Act. The State agency shall not, however, be a party to or assume any responsibility for defending any determination made by the Secretary pursuant to Title II of the Act. Notification to the individual of the determination of disability will be made by the Secretary at the same time such individual is notified whether his insurance rights under Title II of the Act are preserved on account of his disability or whether he is entitled to a benefit under Title II of the Act.

7. From time to time the Secretary will review such standards as he may issue pursuant to this agreement and, to the extent feasible, will consult with, and take into consideration the experience of, States or such group of States as he may consider representative, with which agreements have been entered into to carry out the disability provisions of the Act, to determine the standards that are necessary and sufficient to effectuate the purposes of this agreement.

C. *Personnel*

In carrying out this agreement, the State agency further agrees that it will comply in all respects with the provisions set out in Section 202 of Executive Order 11246 of September 24, 1965, as amended by Executive Order 11375 of October 13, 1967 (a copy of which is attached hereto and made a part hereof). The State agency will also, except as may be inconsistent with the foregoing, adhere to its approved personnel standards in its plan under the Vocational Rehabilitation Act (29 U.S.C. 31 et seq.) or if there are no approved personnel standards for a particular position, such standards in the selection, tenure of office, or compensation of any individual in such position as are consistent with the personnel standards in its plan under the Vocational Rehabilitation Act.

D. *Organization*

1. As may be agreed upon by the State agency and the Secretary, the State agency will provide such facilities, employ such qualified personnel, and provide such medical consultative services as are necessary to develop expeditiously evidence with respect to disability determinations. Such personnel shall be subject to the jurisdiction of the State agency.

2. The determination of disability based upon the evidence developed by such personnel shall be made by a medical consultant and by another individual or individuals qualified to interpret and evaluate medical reports relating to the physical or mental impairment (as referred to under the definition of "disability" in Part A of this agreement) and to determine the capacity of the individual, with respect to whom a determination of disability is necessary, to engage in substantial gainful activity. The personnel utilized by the State agency to make determinations of disability shall be placed in such offices as may be agreed upon by the State agency and the Secretary.

3. The State agency will establish cooperative working relationships with other public agencies concerned with the problems of the disabled and, insofar as practicable, utilize the services, facilities, and records of such agencies (a) to assist the State agency in the development of evidence with respect to and in the making of determinations of disability, and (b) to assure that the Congressional policy promulgated in the Act, relative to the referral of disabled individuals for rehabilitation services, will be carried out effectively. Such public agencies may be reimbursed for such services, facilities or records furnished pursuant to (a), and the State agency shall include such costs in the estimates of anticipated costs and reports of actual expenditures furnished pursuant to Part G.

E. *Medical and other examinations*

1. In making arrangements for medical or other examinations and tests necessary to make determinations of disability, the State agency will pay the fees or costs of such examinations and tests prescribed by the fee schedule in effect for purposes of the State program it administers.

2. Where a particular examination or test is not included in an established fee schedule, the State agency will not bind itself to pay any fee or cost for such examination or test which is in excess of the highest rate paid by Federal or State agencies in the State for the same or a similar type of service.

F. *Reports and records*

The State agency will make such reports in such form and containing such information as the Secretary may require, and will comply with such provisions as the Secretary finds necessary to insure the correctness of such reports, including provisions made for the inspection and review of fiscal, statistical and other records and the review of operations within the scope of this agreement.

G. *Fiscal*

1. The Secretary will provide funds in advance, as may be mutually agreed upon, for the necessary cost to the State agency of making determinations of disability authorized by this agreement. Such funds will either be paid periodically by the Managing Trustee to the Treasurer of the Commonwealth upon certification by the Secretary, or, at the option of the Secretary, will be made available for draft by one of the officials designated by the State for this purpose against letter of credit drawn on a Federal Reserve Bank. Such funds will be used solely for such expenses. Where, for purposes of the State program it administers, the State agency utilizes any service or material purchased or contracted for by it pursuant to this agreement, the cost of such services or material shall, pursuant to standards issued by the Secretary, be prorated and only that part which is attributable to the making of disability determinations authorized by this agreement shall be considered a necessary cost for the purpose of this agreement.

2. The State agency will submit estimates of anticipated costs for such periods, at such times, and in such manner as may be requested by the Secretary. After considering all pertinent information, the Secretary will determine the amount of funds that are necessary for the State agency to administer this agreement for a particular period and that are available to keep within the limits of Federal funds allocated to carry out the purposes of Section 221. The Secretary will notify the State agency the amount which will be certified for payment to it, or made available to it, for such period. The State agency will not incur or make expenditures for such period which will exceed the amount the Secretary certifies or makes available for such period unless in advance of making or incurring such expenditures the State agency obtains approval of the Secretary for such expenditures.

3. After the close of a period for which funds have been certified in advance to the State agency, the State agency will submit a certified report of its actual expenditures for such period in such manner and within such time as may be designated by the Secretary. After considering all the pertinent information, the Secretary will determine whether such expenditures were necessary in making determinations of disability authorized by this agreement under standards in effect at the time such expenditures were made or incurred. If, pursuant to such standards, the Secretary determines that any such expenditure was not necessary for such purpose, the Secretary shall so inform the State agency of tentative exceptions taken, with full explanation of such tentative exceptions. The State agency will be given a reasonable length of time to justify such expenditures. If such expenditures cannot be justified by the State agency, the total amount of expenditures actually made and incurred in such period shall be reduced by any expenditures determined by the Secretary to be not necessary in making determinations of disability authorized by this agreement. The difference between the advance payment made to the State agency and the expenditures determined to be necessary for such period will be adjusted, within the limits of available funds, by either appropriate increase or appropriate reduction in the amount certified for advance by the Secretary for a subsequent period.

4. Any moneys paid to the State which are used for purposes not within the scope of this agreement shall be returned to the Treasury of the United States for deposit in the Trust Fund from which payment was certified.

5. All estimates and reports of expenditures and other reports will be prepared in accordance with appropriate budgetary and accounting methods, and administrative practice as recommended by the Secretary and agreed to by the State agency. The State agency will furnish or make available such supplemental accounts, records, or other information as are required to substantiate any estimate, expenditure, or report, as requested by the Secretary or as may be necessary for auditing purposes or to verify that expenditures were made only for purposes authorized by this agreement.

6. The State agency will comply with such standards as the Secretary may promulgate with respect to the responsibility of, and the accountability by, the State agency for property purchased by it with funds certified by the Secretary to it under this agreement.

H. Confidential nature and limitations on use of disability determination information and records

In accordance with standards promulgated by the Secretary, the State agency will adopt policies and procedures to insure that information contained in its records and obtained from others in connection with carrying out its disability determination functions under this agreement will be used solely for the purpose of making determinations of disability. Such information shall be disclosed only as provided in the Act and the regulations promulgated thereunder by the Secretary.

I. Modification of agreement

This agreement may be modified at any time by mutual consent of the parties to the agreement.

J. Termination by State agency

This agreement may be terminated by the State agency on six months advance notice in writing to the Secretary, or without such advance notice if it certifies to the Secretary and, if requested by the Secretary, such certification is accompanied by an opinion of the Attorney General of the State, that it is no longer legally able to comply substantially with any provision of this agreement.

K. Termination by the Secretary

The Secretary may terminate this agreement on six months advance notice in writing to the State agency. He may terminate it without such notice if he finds that he is no longer legally able to comply substantially with any provision of this agreement and so notifies the State agency in writing or, after affording an opportunity for hearing to the State agency, he finds that the State agency is no longer legally able or has failed to comply substantially with any provision of this agreement. If, under this part or Part J, this agreement is terminated, any funds paid to the State agency under Part G of this agreement which have not been expended or encumbered in accordance with the terms of this agreement prior to the date as of which the agreement was terminated, and any property purchased with funds paid to the State agency under Part G of this agreement, shall be accounted for with due regard to the equities of the parties in such funds and property.

L. Effective date

This agreement shall be effective as of June 27, 1966 and when effective, supersedes as of such date the agreement entered into between the Secretary and the State under date of February 6, 1956 and all modifications thereof.

ATTACHMENT A

1. The State agency will not discriminate against any employee or applicant for employment because of race, [creed], color, religion, sex, or national origin. The State agency will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, [creed], color, religion, sex, or national origin. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The State agency agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

2. The State agency will, in all solicitations or advertisements for employees placed by or on behalf of the State agency, state that all qualified applicants will receive consideration for employment without regard to race, [creed], color, religion, sex, or national origin.

3. The State agency will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by the agency contracting officer, advising the labor union or workers' representative of the State agency's commitments under Section 202 of Executive Order No. 01246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

4. The State agency will comply with all provisions of Executive Order No. 11246 of September 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.

5. The State agency will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the Secretary of Health, Education, and Welfare and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

6. In the event of the State agency's noncompliance with the nondiscrimination clauses of this contract or with any of such rules, regulations, or orders, this contract may be cancelled, terminated or suspended in whole or in part and the State agency may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of September 24, 1965, and

such other sanctions may be imposed and remedies involved as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

7. The State agency will include the provisions of Paragraph (1) through (7) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The State agency will take such action with respect to any subcontract or purchase order as the Secretary of Health, Education, and Welfare may direct as a means of enforcing such provisions including sanctions for noncompliance: Provided, however, That in the event the State agency becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction by the Secretary of Health, Education, and Welfare, the State agency may request the United States to enter into such litigation to protect the interests of the United States.

APPENDIX II. STATISTICS ON DISABILITY CLAIMS, DENIALS, RECONSIDERATIONS, AND APPEALS, FISCAL YEAR 1979

	Title II	Percent	Title XVI	Percent
Initial claims	25,859		27,309	
Initial denials	13,901	53.8	14,028	51.3
Initial approvals	11,958	46.2	13,281	48.6
Received at reconsideration	1,087	18.9	776	17.7
Total denials after reconsideration	12,814		13,252	

Note: Fiscal year 1978: total of 3,499 requests for hearing, 1,800 plus reversals (53 percent): approximately 1,699 lost at hearing; approximately 221,567 never requested hearing.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Boston, Mass.

MR. MARK S. COVEN,
Greater Boston Elderly Legal Services,
Boston, Mass.

DEAR MR. COVEN: This is in response to your request of February 6 for information concerning Title II and Title XVI applications for disability benefits. The figures below represent data for fiscal year 1979 for the State of Massachusetts only and are based on the number of claims filed rather than the number of individuals involved, i.e. 8323 initial Title II disability applicants also filed concurrent Title XVI claims.

1. A. Number of Title II disability claims—25,859; number of Title XVI disability claims—27,309.

B. Number of DDS medical denials—Title II 13,901—62.4 percent of DDS medical denials. Number of DDS medical denials—Title XVI 14,028—66.9 percent of DDS medical denials.

C. We do not have exact figures for the number and percentage of medical denials cases in which reconsideration was requested. However, comparing the number of reconsideration medical decisions to the number of initial denials we estimate that 41 percent of the Title II denials and 31 percent of the Title XVI denials result in a reconsideration request.

D. Out of 5,755 Title II reconsideration requests 1,087 (18.9 percent) resulted in a reversal of the original denial; of 4,389 Title XVI reconsideration requests 776 (17.7 percent) decisions were reversals of the original denial.

2. The monthly denial rates for fiscal 1979 are as follows:

	Title II	Title XVI
September 1979	69.6	69.2
August 1979	67.1	69.6
July 1979	66.5	73.8
June 1979	64.9	65.9
May 1979	65.9	69.2
April 1979	68.2	69.6
March 1979	65.6	71.1

	Title II	Title XVI
February 1979	66.1	70.0
January 1979	65.1	71.3
December 1978	67.3	68.9
November 1978	64.0	67.5
October 1978	64.8	66.7

In response to your request for copies of all DDS instructions we are assembling and photocopying the regional supplements issued to the DDS's by this office. Since this may take some time we are sending them to you under separate cover. In addition there are a series of national instructions issued through the Office of Programs Directives (Room 2140 West High Rise, Baltimore Maryland 21235) and we are sending a copy of your letter to that office. You should hear from them shortly concerning your request for a copy of this material.

We regret that we are unable to supply information concerning claims at the hearing level and above since we do not maintain that type of data in this office. However, we are referring your request to the Office of Hearings and Appeals (JFK Federal Building, Government Center, Room E-310 Boston, Massachusetts 02203) since they may be able to supply you with this information. You should be hearing from them shortly.

If we can be of further assistance please do not hesitate to contact us.

Sincerely yours,

ROBERT C. GREEN,
Regional Commissioner.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Boston Mass., March 3, 1980.

Mr. MARK S. COVEN,
Greater Boston Elderly Legal Services,
Boston, Mass.

DEAR MR. COVEN: Since part of your request for statistical information concerns cases at the hearing level and above, it has been referred to our office by Mr. Green, the regional commissioner.

The following information covers the fiscal year 10/78 through 9/79. During this time frame 3499 requests for hearing were received by our Boston hearing office. The reversal rate was slightly over 53 percent during this period so that 1800 plus cases resulted in payments to the claimants.

Appeals beyond the hearing level to the Appeals Council and to the U.S. District Court are not channelled through the hearing offices. I have spoken to our central office, and they suggest that you contact them directly for the rest of the information you are seeking. They did point out that statistics above the hearing level were available on a national basis only. To obtain this information, please write to the following address: Social Security Administration, Office of Hearings and Appeals, Division of Management, Information Systems, P.O. Box 2518, Washington, D.C. 20013.

I hope this will provide you with the information that you want, and if we can be of any further service please let us know.

Sincerely,

DARLENE A. WICHTERMAN,
Regional Management Officer, Office of Hearings and Appeals.

APPENDIX III. NATIONAL STATISTICS

V. TABLES—NATIONAL DATA

TABLE I.—SELECTED DATA ON DISABILITY INSURANCE PROGRAM, 1968–77—ALL LEVELS

[Note: For earlier years see the "Committee Staff Report on the Disability Insurance Program," July 1974]

	12 mos. ended June—						
	1968	1970	1972	1974	1975	1976	1977
I. Initial disability claims:							
A. Number of claims decided [1]	638,000	765,800	1,016,100	1,140,600	1,342,600	1,272,900	1,252,500
B. Claims requiring determination of disability [2]	510,300	609,500	836,700	930,400	1,101,100	1,050,500	1,070,800
Worker	463,400	542,800	754,800	832,200	1,003,800	900,800	932,100
Widow	25,400	37,600	44,700	61,500	56,400	52,600	51,500
Child	27,500	29,100	37,200	42,700	40,900	43,100	40,200
C. Number of claims allowed [3]	349,300	382,300	505,300	555,200	653,700	607,600	586,700
Worker [4]	314,800	344,400	461,300	499,500	605,400	558,200	540,100
Widow	12,600	16,200	18,300	24,800	19,800	18,900	18,300
Child	21,900	21,700	25,700	30,900	28,500	30,500	28,300
D. Number allowed as percent of I.B	67.7	62.7	60.4	59.3	59.4	57.5	56.9
Worker	67.9	63.4	61.1	60.0	60.3	58.1	57.5
Widow	49.6	43.1	40.9	40.3	35.1	35.8	35.5
Child	70.6	74.6	69.1	72.4	69.7	70.6	70.4
E. Number allowed on initial determination	317,400	335,500	426,800	464,800	540,700	497,900	[5] 480,500
Worker	283,200	299,900	385,900	413,100	497,000	453,200	[5] 438,400
Widow	12,600	14,300	15,900	21,700	16,200	[5] 15,200	[5] 14,600
Child	21,600	21,300	25,000	[5] 30,000	[5] 27,500	[5] 29,500	[5] 27,500
F. Allowed on initial determination as percent of I.C	90.9	87.8	84.5	83.7	82.7	82.0	81.9
Worker	90.0	87.1	83.6	82.7	82.1	81.2	81.2
Widow	100.0	88.3	86.9	87.5	81.8	80.6	79.8
Child	98.6	98.2	97.3	97.1	96.5	96.9	97.2
G. Cases initially denied—all reasons	321,700	430,300	589,300	684,800	801,900	775,000	772,000
Worker	301,900	396,900	545,900	630,800	746,900	722,100	720,700
Widow	13,300	24,900	30,300	41,000	41,200	38,700	38,300
Child	6,500	8,500	13,100	13,000	13,800	14,200	13,000
H. Denied for failure to meet disability test	193,900	274,000	409,900	471,600	560,400	558,600	550,300
Worker	180,200	242,900	368,900	419,100	506,800	507,600	500,700

Widow	12,800	23,300	28,800	39,800	40,200	37,400	36,900
Child	5,900	7,800	12,200	12,700	13,400	13,600	12,700
II. Reconsideration of initial denials:							
A. Total reconsideration determinations	67,400	97,700	159,500	188,400	237,200	239,100	219,500
Worker	66,500	91,200	149,000	175,300	221,800	223,100	205,800
Widow		5,200	8,200	10,500	12,300	12,400	10,900
Child	900	1,300	2,300	2,600	3,100	3,600	2,800
B. Number allowed after reconsideration	23,400	32,300	58,200	63,700	79,100	69,800	[5] 60,800
Worker	23,100	30,700	55,600	60,400	75,400	66,400	[5] 57,700
Widow		1,200	1,900	2,400	2,700	[5] 2,400	[5] 2,300
Child	300	400	700	900	1,000	[5] 1,000	[5] 800
C. Allowed after reconsideration as percent of II.A	34.7	33.1	36.5	33.8	33.3	29.2	27.7
Worker	34.7	33.7	37.3	34.5	34.0	29.8	28.0
Widow		23.1	23.2	22.9	22.0	19.4	21.1
Child	33.3	25.0	30.4	34.6	32.3	27.8	28.6
III. BHA action in initial claims: [6]							
A. Number of hearings cases in which action was taken	26,260	31,300	43,900	51,400	5,200	82,400	[5] 92,100
Worker and child	20,200	29,100	41,800	49,100	62,100	77,800	87,400
Widow		2,200	2,100	2,300	3,100	4,600	4,700
B. Number allowed by ALJ's	7,000	13,300	19,200	24,100	31,800	37,900	43,100
Worker and child	7,000	12,600	18,700	23,400	30,900	36,600	41,700
Widow		700	500	700	900	1,300	1,400
C. Number allowed by appeals Council	600	800	700	1,900	1,300	1,200	1,000
D. Total allowed as percent of total actions taken (B plus C divided by A)	42.1	45.0	45.3	50.6	50.8	47.5	47.9
IV. Court actions:							
A. Number of court actions filed	916	1,361	1,700	2,440	3,165	5,016	5,824
B. Number of dispositions (including dismissals)	692	1,014	1,200	1,810	2,094	2,319	3,205
C. Cases allowed after court action	102	162	150	239	210	215	249
D. Allowed by Appeals Council after remand	211	211	200	421	560	615	1,008
E. Total allowed	313	373	350	606	770	830	1,257
F. Total allowed as percent of IV.B	45.2	36.8	29.2	36.5	36.8	35.8	39.2
V. Continuing disability investigations:							
A. Number of determinations	152,900	166,700	167,200	158,600	[7] 147,200	170,000	154,200
Worker	149,200	162,600	161,900	151,500	141,600	164,900	150,800
Widow			900	900	600	800	500
Child	3,700	4,100	4,400	6,200	5,000	[9] 4,300	[8] 1,900

Footnotes at end of table.

TABLE I.—SELECTED DATA ON DISABILITY INSURANCE PROGRAM, 1968–77—ALL LEVELS—Continued

[Note: For earlier years see the "Committee Staff Report on the Disability Insurance Program," July 1974]

	12 mos. ended June—						
	1968	1970	1972	1974	1975	1976	1977
B. Number terminated	34,900	43,300	39,100	38,700	[7] 31,300	40,900	45,750
Worker	33,300	41,400	36,900	35,700	28,900	38,850	44,200
Widow			300	300	200	250	200
Child	1,600	1,900	1,900	2,700	2,200	[8] 1,800	[8] 1,350
C. Terminated cases as percent of V.A.	22.8	26.0	23.4	24.4	21.3	24.1	29.7
Worker	22.3	25.5	22.8	23.6	20.4	23.6	29.3
Widow			33.3	33.3	33.3	32.1	40.0
Child	43.2	46.3	43.2	43.5	44.0	42.2	46.6

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[1] Sum of cases initially allowed and initially denied (E. plus (G).

[2] Sum of cases initially allowed and initially denied for failure to meet disability test (E. plus (H).

[3] Includes all allowances—initial, reconsideration, hearing, and court action.

[4] May include a few hearing reversals in childhood disability cases.

[5] Estimate based on number of awards.

[6] Excludes hearings in title II claims; which are concurrent with title XVI claims, such hearings are counted only as hearings in title XVI claims. Data for 1977 includes an estimate for June.

[7] High initial title II and title XVI workloads in 1974 and 1975 forced deferral of diaried medical reexaminations, resulting in a decline in terminations recorded in fiscal year 1975.

[8] This number may be understated as the result of changes in data processing procedures.

[9] Initial denial data for the 12 mos. ended June 1977 may be slightly overstated and may be adjusted after editing and retabulation.

TABLE II.—STATE AGENCY DETERMINATIONS DENIED IN INITIAL WORKER CLAIMS TITLE II

[In percent]

	Fiscal year—			
	1974	1975	1976	1977
United States	50.5	50.1	52.2	54.4
Alabama	60.5	56.5	[1] 64.5	64.5
Alaska	[1] 63.0	53.1	53.5	56.6
Arizona	56.6	54.9	53.2	51.9
Arkansas	58.2	56.2	59.0	63.4
California	52.6	51.5	51.3	55.6
Colorado	51.9	51.7	52.2	55.5
Connecticut	41.0	41.1	42.8	47.3
Delaware	47.3	45.2	46.6	52.1
District of Columbia	57.1	48.7	52.6	57.5
Florida	48.9	50.5	56.6	58.1
Georgia	54.9	53.1	54.6	56.8
Hawaii	51.0	53.0	52.5	53.3
Idaho	53.5	52.3	52.8	56.5
Illinois	50.9	57.1	54.5	59.1
Indiana	46.2	45.5	48.3	50.7
Iowa	[2] 36.6	[2] 34.4	44.2	48.8
Kansas	51.4	53.1	51.0	50.3
Kentucky	61.0	61.1	62.8	60.5
Louisiana	56.8	55.5	55.5	58.1
Maine	47.5	39.3	50.3	53.5
Maryland	53.0	56.4	56.4	60.3
Massachusetts	44.0	47.0	50.6	54.8
Michigan	50.0	52.9	52.0	54.4
Minnesota	39.4	41.7	43.1	47.4
Mississippi	58.6	58.4	55.1	59.8
Missouri	48.8	48.4	49.9	54.0
Montana	48.8	50.8	53.2	55.4
Nebraska	51.2	45.9	46.5	48.3
Nevada	57.7	52.1	57.6	56.4
New Hampshire	55.0	52.1	57.9	56.9
New Jersey	37.7	36.6	[2] 41.8	[2] 40.2
New Mexico	62.1	[1] 61.9	60.6	[1] 66.7
New York	45.9	46.1	51.0	47.8
North Carolina	48.9	47.6	49.7	54.1
North Dakota	50.2	46.9	53.4	55.3
Ohio	42.1	43.3	46.3	49.5
Oklahoma	55.0	53.1	54.3	59.6
Oregon	49.3	52.3	55.2	60.9
Pennsylvania	47.9	48.8	47.0	47.4
Rhode Island	43.4	43.2	45.8	46.9
South Carolina	55.3	57.9	56.9	57.2
South Dakota	47.2	45.3	47.6	52.3
Tennessee	52.1	52.0	56.1	62.4
Texas	55.8	53.9	58.1	60.6
Utah	49.4	48.2	46.6	50.7
Vermont	51.1	45.2	49.3	49.6
Virginia	61.3	59.6	63.0	61.3
Washington	45.1	43.2	48.9	53.0
West Virginia	59.1	50.7	55.7	60.4
Wisconsin	43.9	42.1	44.8	47.5
Wyoming	56.0	54.8	60.0	59.3
Puerto Rico	52.6	50.6	54.3	59.9
Virgin Islands	53.1	50.0	48.2	42.2
Guam	64.6	58.1	59.7	59.4

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[1] High.
[2] Low.

TABLE III.—STATE-BY-STATE BASIS FOR ALLOWANCE [1]—TITLE II, INITIAL WORKER DETERMINATION, FISCAL YEARS 1975–77

[In percent]

States by region	Meets medical listing			Equals medical listing			Medical factors plus nonmedical factors (i.e., vocational, educational, and advanced age)		
	1975	1976	1977	1975	1976	1977	1975	1976	1977
United States	29.4	29.0	34.2	43.9	45.1	41.9	26.7	25.9	23.9
Boston:									
Connecticut	41.4	45.1	55.5	39.2	37.0	22.7	19.3	17.9	21.8
Maine	31.6	33.0	43.6	48.6	43.7	33.6	19.8	23.2	22.8
Massachusetts	30.5	30.6	33.2	46.8	45.0	44.4	22.7	24.3	22.4
New Hampshire	55.6	56.6	60.2	29.9	26.1	24.5	14.4	17.3	15.3
Rhode Island	44.9	44.4	52.9	32.4	32.7	27.1	22.7	22.9	20.0
Vermont	31.1	27.1	34.5	45.7	46.3	42.1	23.2	26.6	23.4
New York:									
New Jersey	17.6	17.3	17.2	68.2	66.2	65.4	14.2	16.4	17.3
New York	14.2	12.4	15.8	58.1	61.9	63.8	27.7	25.6	20.4
Puerto Rico	26.6	25.3	28.3	56.8	55.0	54.0	16.6	19.7	17.7
Philadelphia:									
Delaware	51.2	50.4	51.8	27.5	27.6	24.7	21.4	21.9	23.5
District of Columbia	24.7	15.9	20.2	50.8	62.9	55.3	24.5	21.2	24.5
Maryland	38.4	37.2	43.6	43.2	43.2	40.3	18.4	19.5	16.1
Pennsylvania	35.7	32.2	33.8	36.5	38.7	38.2	27.8	29.0	28.0
Virginia	52.6	51.8	52.2	26.7	29.0	26.8	20.6	19.2	21.0
West Virginia	21.4	26.1	33.1	44.5	48.0	43.6	34.1	25.9	23.3
Atlanta:									
Alabama	31.6	30.5	38.0	33.5	38.0	32.4	34.9	31.4	29.6
Florida	32.4	33.2	33.4	39.7	43.7	46.6	27.8	23.0	20.0
Georgia	24.2	26.1	35.0	41.7	16.2	39.7	34.2	27.7	25.6
Kentucky	32.0	36.2	40.1	42.5	43.5	38.2	25.6	20.2	21.7
Mississippi	23.0	21.8	27.8	46.1	45.6	44.4	30.9	32.6	27.8
North Carolina	32.9	35.9	42.8	43.0	41.8	38.3	24.1	22.2	16.9
South Carolina	24.4	25.9	28.7	50.6	47.7	46.3	25.0	26.3	25.0
Tennessee	19.8	23.7	44.9	50.8	50.5	30.4	29.3	25.7	24.7
Chicago:									
Illinois	31.8	26.8	40.0	47.0	49.4	42.4	21.0	23.8	17.6
Indiana	24.0	22.5	27.8	55.9	58.4	52.7	20.0	19.0	19.5
Michigan	24.0	27.2	44.2	39.3	39.2	23.8	36.6	33.5	32.0
Minnesota	40.6	35.3	42.3	30.3	34.8	30.2	29.0	29.8	27.5
Ohio	25.4	26.2	34.6	49.5	53.0	42.1	25.0	21.7	23.3
Wisconsin	32.3	32.0	33.0	45.7	46.7	44.9	22.0	21.3	22.0
Dallas:									
Arkansas	23.1	22.1	26.7	50.2	55.6	62.4	26.6	22.3	10.9
Louisiana	30.8	26.4	23.7	47.0	51.6	51.7	22.2	22.0	24.6
New Mexico	35.7	36.8	36.9	32.0	30.3	31.6	32.2	32.8	31.5
Oklahoma	29.3	29.5	34.5	55.6	53.2	44.3	15.2	17.3	21.2
Texas	32.5	34.3	34.2	36.1	39.2	40.3	31.4	26.4	25.5
Kansas City:									
Iowa	37.4	43.8	56.4	42.5	32.5	21.0	20.1	23.7	22.6
Kansas	54.8	55.6	53.1	28.3	21.9	25.1	16.9	22.5	21.8
Missouri	32.5	35.0	46.8	43.6	39.1	31.9	23.9	25.8	21.3
Nebraska	45.0	50.2	56.4	35.6	28.5	22.2	19.4	21.4	21.4
Denver:									
Colorado	35.8	36.2	38.4	40.9	41.8	38.5	23.2	22.0	23.1
Montana	43.7	45.6	53.1	28.3	27.6	17.1	27.9	26.7	29.8
North Dakota	59.1	59.2	66.6	19.2	20.7	17.4	21.6	20.0	16.0
South Dakota	47.9	50.1	60.5	27.7	28.0	21.2	24.4	21.8	18.3
Utah	42.9	45.9	48.5	38.8	33.6	26.6	18.3	20.5	24.9
Wyoming	43.2	48.9	52.9	34.4	29.6	29.9	22.3	21.4	17.2
San Francisco:									
Arizona	32.4	25.3	35.3	38.8	43.9	36.5	28.8	30.8	28.2
California	32.7	29.7	34.1	31.2	33.8	30.1	36.0	36.5	35.8

Footnote at end of table.

TABLE III.—STATE-BY-STATE BASIS FOR ALLOWANCE [1]—TITLE II, INITIAL WORKER DETERMINATION, FISCAL YEARS 1975–77—Continued

[In percent]

States by region	Meets medical listing			Equals medical listing			Medical factors plus nonmedical factors (i.e., vocational, educational, and advanced age)		
	1975	1976	1977	1975	1976	1977	1975	1976	1977
Guam	73.1	79.3	89.7	11.5	6.9	3.4	15.4	13.8	6.9
Hawaii	56.6	54.6	55.6	26.5	31.5	31.9	16.8	13.9	12.5
Nevada	20.2	26.4	38.2	54.4	47.8	41.2	25.4	25.7	20.6
Seattle:									
Alaska	39.7	43.4	40.5	29.3	42.7	38.1	30.9	13.9	21.4
Idaho	31.0	26.5	30.3	28.9	30.3	34.2	40.0	43.1	35.5
Oregon	45.5	39.9	43.6	33.1	38.6	33.4	21.3	21.5	22.9
Washington	31.7	28.8	33.4	36.1	37.2	37.0	32.3	34.0	29.6

[1] Based on State agency classification of case.

TABLE IV.—STATE-BY-STATE BASIS FOR ALLOWANCE—TITLE II, INITIAL WORKER DETERMINATION, FISCAL YEAR 1974 AND CALENDAR YEAR 1977

[In pecent]

States by region	State agency—fiscal year 1977[1]			Social Security physicians—calendar year 1977[2]		
	Meets medical listing	Equals medical listing	Medical factors, plus nonmedical factors (i.e., vocational education, and advanced age)	Meets medical listing	Equals medical listing	Medical factors, plus nonmedical factors (i.e., vocational educational and advanced age)
United States	34.2	41.9	23.9	50	22	28
Boston:						
Connecticut	55.5	22.7	21.8	51	20	29
Maine	43.6	33.6	22.8	51	19	30
Massachusetts	33.2	44.4	22.4	50	26	24
New Hampshire	60.2	24.5	15.3	59	21	20
Rhode Island	52.9	27.1	20.0	53	17	30
Vermont	34.5	42.1	23.4	51	23	26
New York:						
New Jersey	17.2	65.4	17.3	48	29	23
New York	15.8	63.8	20.4	37	27	36
Puerto Rico	28.3	54.0	17.7	50	22	28
Philadelphia:						
Delaware	51.8	24.7	23.5	55	21	24
District of Columbia	20.2	55.3	24.5	46	24	30
Maryland	43.6	40.3	16.1	57	19	24
Pennsylvania	33.8	38.2	28.0	48	25	27
Virginia	52.2	26.8	21.0	57	23	20
West Virginia	33.1	43.6	23.3	40	29	31
Atlanta:						
Alabama	38.0	32.4	29.6	54	19	27
Florida	33.4	46.6	20.0	49	21	30
Georgia	35.0	39.7	25.3	42	26	32
Kentucky	40.1	38.2	21.7	53	27	20
Mississippi	27.8	44.4	27.8	46	24	30
North Carolina	42.8	38.3	16.9	53	26	21
South Carolina	28.7	46.3	25.0	42	24	34
Tennessee	44.9	30.4	24.7	54	19	27

Footnotes at end of table.

TABLE IV.—STATE-BY-STATE BASIS FOR ALLOWANCE—TITLE II, INITIAL WORKER DETERMINATION, FISCAL YEAR 1974 AND CALENDAR YEAR 1977—Continued

[In pecent]

States by region	State agency—fiscal year 1977[1]			Social Security physicians—calendar year 1977[2]		
	Meets medical listing	Equals medical listing	Medical factors, plus nonmedical factors (i.e., vocational education, and advanced age)	Meets medical listing	Equals medical listing	Medical factors, plus nonmedical factors (i.e., vocational educational and advanced age)
Chicago:						
Illinois	40.0	42.4	17.6	49	22	29
Indiana	27.8	52.7	19.5	51	25	24
Michigan	44.2	23.8	32.0	52	19	29
Minnesota	42.3	30.2	27.5	55	19	26
Ohio	34.6	42.1	23.3	52	22	26
Wisconsin	33.0	44.9	22.1	44	26	30
Dallas:						
Arkansas	26.7	62.4	10.9	58	31	11
Louisiana	23.7	51.7	24.6	44	30	26
New Mexico	36.9	31.6	31.5	44	20	36
Oklahoma	34.5	44.3	21.2	49	24	27
Texas	34.2	40.3	25.5	46	27	27
Kansas City:						
Iowa	56.4	21.0	22.6	58	15	27
Kansas	53.1	25.1	21.8	54	23	23
Missouri	46.8	31.9	21.3	56	17	27
Nebraska	56.4	22.2	21.4	55	18	27
Denver:						
Colorado	38.4	38.5	23.1	46	25	29
Montana	53.1	17.1	29.8	50	20	30
North Dakota	66.6	17.4	16.0	65	17	18
South Dakota	60.5	21.2	18.3	54	20	26
Utah	48.5	26.6	24.9	50	19	31
Wyoming	52.9	29.9	17.2	44	23	33
San Francisco:						
Arizona	35.3	36.5	28.2	49	24	27
California	34.1	30.1	35.8	41	21	38
Hawaii	55.6	31.9	12.5	53	25	22
Nevada	38.2	41.2	20.6	48	26	26
Seattle:						
Alaska	40.5	38.1	21.4	54	18	28
Idaho	30.3	34.2	35.5	39	19	42
Oregon	43.6	33.4	22.9	47	21	32
Washington	33.4	37.0	29.6	46	22	32

[1] Based on State agency classification of case.

[2] Based on quality assurance medical review sample data, calendar year 1977. Totals are rounded.

Chairman PICKLE. I have a question, a comment to make, Mr. Coven, but we will ask the panelists to continue. We will hear testimony from Eileen Sweeney representing the National Senior Citizens.

STATEMENT OF EILEEN P. SWEENEY, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER, ON BEHALF OF THE GRAY PANTHERS AND THE LEGISLATIVE COUNCIL OF OLDER AMERICANS, INC.

Ms. **Sweeney**. Mr. Pickle, thank you for the opportunity to testify before you today. I am Eileen Sweeney, staff attorney, National Senior Citizens Law Center, appearing here today on behalf of the Gray Panthers and the Legislative Council on Older Americans. I have submitted a written statement which I request that you accept for the record.

My written statement reflects a number of matters which are of concern to us. I will limit my discussion to five points: CDI's and relevant portions of H.R. 5700; requiring that all levels be bound by the social security rulings and the POMS; closing the evidentiary record on reconsideration; the creation of a social security court; and eliminating the remand authority of the courts.

As you have heard from other witnesses, large numbers of severely disabled people are being cut from the rolls. As Senator Riegle noted, this is clearly a budget-saving measure. The message is cut, and we really do not care who you cut, although you should start by cutting people with the largest monthly benefits.

There needs to be a change in the message which state agency personnel are receiving. Instead of "cut," they should be told to take the time to properly and fully develop all of the evidence and then make an informed and fair decision. We propose that the following steps be taken in order to change the message to emphasize that accuracy takes priority over excessive time and budget consciousness.

First, SSA should be required to shift the emphasis in its regulations covering the State-Federal relationship away from timeliness and toward a system which clearly states that SSA values accuracy as well as timeliness, and will seriously evaluate state performance for proper evidence development.

In conjunction with the first proposal, SSA should be required to slow down the CDI process. Without a massive influx of additional personnel, States are simply not capable of handling the volume of cases they are currently receiving. The result is the shoddy work and skewed priorities already mentioned. For example, it is appalling to note the number of States which consider a physician's turnaround time in filing reports to be a major factor in determining appropriate consultative referrals.

Third, we agree with Mr. Svahn's statement that SSA must be reviewing the State disallowances. We believe the Congress should require SSA to review at least a specific percentage of these cases.

Currently, as Mr. Svahn recognized, the easiest action for an overworked DDS staff person to take is to deny the claim or terminate benefits. The chances of that case ever being reviewed is negligible.

Fourth, aid pending review should be provided in title II cases through the ALJ level. Finally, definition of disability should be amended to clarify that before a person's benefits may be terminated, there must be a showing that his or her medical condition has improved or that the original decision affording benefits was clearly erroneous.

The provisions of H.R. 5700 addressing the cessation cases are helpful, but I am afraid they are not enough. All are premised on the assumption that those being cut off are able to work, when they are not, and that the CDI problem will ease by the end of 1984, which we do not believe is very likely.

Therefore, while we would encourage you to enact these provisions, we believe that the proposals which I have previously mentioned will more directly benefit beneficiaries and also will improve the quality of the adjudicatory process at the lower levels.

Section 7 of H.R. 5700 would require that ALJ's be bound not only by the statute and regulations, but also by the social security rulings and the POMS. I discussed this matter in some detail at pages 10 to 12 of my statement. Basically, they should not be permitted to bind the entire administrative process to a set of rules which are virtually immune from public or judicial scrutiny.

We agree that it would be extremely helpful to have all levels of review following the same set of rules. We suggest, however, that the proper course is to require that SSA make proper use of its Federal regulatory powers and issue regulations which can be used by DDS people as well as the ALJ's and the public.

As I will mention later, SSA has traditionally used the POMS and the social security rulings to avoid the effect of various court rulings. It strikes us as a perversion of the administrative agency's role to permit it to simply ignore court decisions by hiding policy in the depths of its procedural manuals.

We are very concerned about the social security proposal. As you will note, a large portion of my written statement is devoted to a discussion of the proposed court. I cite you to pages 16 to 28 of my statement.

Chairman PICKLE. Let me interrupt you. Are you reading from your statement or are you reading from a summary? I cannot keep up with you.

Ms. SWEENEY. I am sorry, sir. I just digested my statement. You do not have a copy of what I have.

Chairman PICKLE. I see, you have a very lengthy statement. We will include your statement in the record. Are you reading from any part of your testimony? It might be helpful to keep up with you. I am trying to and I cannot.

Ms. SWEENEY. I apologize. I am reading from notes that I took last night from my statement.

Chairman PICKLE. All right.

Ms. SWEENEY. You have indicated concern with the incredible delays in the Federal courts in these cases. We are equally concerned. However, we believe that an investigation of SSA's role in creating that delay would be a more appropriate step at this time.

I refer you to exhibits 2 and 3 attached to my testimony. In exhibit 2 the Northern District of California regularly grants the Secretary extensions of time in which to answer without the Secretary even having to ask. Exhibit 3 is a letter written in 1975 and filed by the Secretary in an action in 1980 in which SSA explains to the Justice Department why it is so slow in filing answers.

This suggests to me that there may be many less drastic ways of addressing your legitimate concerns than the creation of a new court structure. Also, because SSA is a part, a large part of the problem, creation of a new court is not likely to eliminate the delays which currently exist.

Mr. Pickle, you have also cited the need for uniformity in SSA's practice of nonacquiescing as facts supporting the need for a new court. We look at the facts and see just the opposite. The record is clear that SSA makes absolutely no effort to follow court rulings. We think it would be unwise to reward SSA for this illegal behavior.

The case which Mr. Shannon questioned Mr. Hays about just yesterday is an excellent example. In Finnegan, the ninth circuit ruled that SSA could not terminate grandfathered SSI recipients unless there was evidence of medical improvement or that the initial decision was clearly erroneous. Mr. Hays indicated SSA would only follow decisions of the Supreme Court; however, SSA did not appeal Finnegan to the Supreme Court. Instead, it decided to ignore it, just like it has done with so many other rulings of the circuit courts of appeals.

Attached to my statement is exhibit 4. It is a very instructive memo outlining SSA's reasons for not appealing to the Supreme Court in Finnegan, and instead, issuing a ruling nonacquiescing in Finnegan. I note that the vehicle for non-acquiescence was a social security ruling, one of the very same items which H.R. 5700 would require to be statutorily binding upon ALJ's.

Mr. Hays also justified nonacquiescence on the grounds that this has been SSA's approach to cases for years. That SSA has been acting illegally for years does not make its actions legal. Two circuit courts of appeals have held the identical practice of the NLRB to be illegal. Those cases are cited at page 22 of my statement. We recommend that SSA be required to follow the law for a few years and then Congress should come back and reevaluate the need for a social security court.

In the statement, we address the specific provisions of the social security court proposal and recommend the following: one, the court should be subject to the Federal Rules of Civil Procedure; two, filing fees should be automatically waived for certain categories of people including SSI applicants and beneficiaries, and beneficiaries and applicants in concurrent cases; three, there should be no limitation on either the types of issues which can be appealed from the court, nor upon the geographic location of the courts to which appeals may be taken. Four, given the limited number of judges and the likelihood that claimants will have to travel much greater distances to be heard, provision should be made to cover the travel cost of appellants.

We also question the wisdom of eliminating court remands. If you eliminate the power of courts to remand cases to the Secretary, even after reversal of the Secretary's ruling, it is difficult to determine what will happen to these cases and how claimants will ever receive the benefits to which they are entitled.

Courts usually reverse the Secretary for reasons such as the Secretary failed to obtain necessary evidence, or an ALJ asked an improper hypothetical of a vocational expert and then relied upon the opinion. Without a remand, district courts will be required to receive and consider the additional evidence. This process is not desirable and we would recommend this provision be deleted.

We are strenuously opposed to closing the record after reconsideration. We agree with the notion that the reconsideration level needs help. Unfortunately, as written, H.R. 5700 requires that the appellants bear the entire burden of making the system work. The approach is both unrealistic and unfair. The price which appellants will pay for policing the system is more delay. They will be required to bounce back and forth between the various levels of review just to develop the evidentiary record.

In addition, the bill unfairly shifts an even greater burden on the unrepresented claimant to obtain all evidence on their own. The ALJ's will no longer be there to assist, and, while there are exceptions, the State levels have not provided that assistance. Nothing in the bill will change that.

It is also unrealistic to expect the claimant—sought remands will result in systematic cleanup of the reconsideration stage. The States will simply let cases pass knowing if there is additional evidence the claimant will be returning with that information at some point.

I would also note that Mr. Lomax from NADE has indicated to you that attorneys tell clients not to file evidence at the reconsideration level. This is the justification for closing the record at that point. I think this is a real chicken and egg problem. My experience representing people, I think the experience of most people has been that there is no useful purpose in going to the reconsideration level; that it is a rubber stamp process of initial denial.

The result of that is that if you are concerned that your client get benefits as soon as possible, you want to get through the State level as fast as possible. So there is no reason to submit additional evidence because it will be ignored.

We would think it much more appropriate—if you want to beef up the recon level, that you require they do proper evidence development at the State level and then keep the process as it currently is. ALJs would have a great deal less work to do if the evidence was in the file when they received it. We also suspect there would be far fewer reversals because fewer cases would be being appealed because they would have been properly adjudicated at the lower level.

We believe that the suggestions we have made with regard to changes needed to remedy the CDI crisis will also improve the reconsideration level. Much like you decided there was a need to create incentives and disincentives to assure that people who are able to work do so, we believe it is necessary to provide similar schemes for State DDS personnel. If adequate evidence development becomes a valued activity, and States are rewarded for that activity, the job will be properly done.

Thank you for this opportunity to testify.

[The prepared statement follows:]

STATEMENT OF EILEEN P. SWEENEY, STAFF ATTORNEY, NATIONAL SENIOR CITIZENS LAW CENTER ON BEHALF OF THE GRAY PANTHERS AND THE LEGISLATIVE COUNCIL OF OLDER AMERICANS

I am Eileen P. Sweeney, a staff attorney at the National Senior Citizens Law Center (NSCLC), appearing on behalf of the Gray Panthers and the Legislative Council of Older Americans. We are most appreciative of the opportunity to appear before the Subcommittee today.

NSCLC is a national support center, specializing in the legal problems of elderly poor people. We are funded by the Legal Services Corporation and the Administration on Aging. Pursuant to the Law Center's Legal Services Corporation grant, we provide support services to legal services attorneys throughout the country with respect to the legal problems of their elderly clients. Under the Administration on Aging grant, NSCLC will be providing training and planning assistance to the states, and will be developing strategies to resolve the legal problems of older people without the direct delivery of services. My responsibilities include working with legal services and aging advocates on the Social Security and Supplemental Security Income problems of their clients.

The Gray Panthers is a non-profit organization incorporated in Pennsylvania, with its headquarters in Philadelphia. It has an estimated membership of 40,000 persons who reside throughout the United States. Its members seek to reform various laws and institutions which affect the lives of the elderly, including Social Security and Supplemental Security Income.

The Legislative Council of Older Americans, Inc. is a statewide non-profit organization representing approximately 48,000 senior citizens in Massachusetts. The Council's primary interests are income maintenance, health care and housing issues; issues which the Council advocates before the Massachusetts state legislature. The Council was founded in 1968 by its president, Frank J. Manning.

These are very troubling times for the administration of the Social Security and SSI disability programs. While this hearing has been scheduled to address the various provisions of H.R. 5700, we believe that it is critical that the Subcommittee focus its attention on the abuses in the continuing disability investigations (CDIs) process. Unfortunately, many provisions of H.R. 5700 will only serve to reward SSA and the state agencies for their arbitrary, often illegal and certainly callous, treatment of thousands of severely disabled Americans.

My testimony therefore first addresses the problems in the CDI program and proposes steps which we believe will remedy the problems. Second, I address specifically a number of provisions in H.R. 5700 with which we are most concerned.

Due to the enormity of the CDI problem and the need to address the various provisions of H.R. 5700 at this hearing, we respectfully request that the Subcommittee schedule a separate hearing to address the CDI issues. Because these issues cannot be separated from much of H.R. 5700, we also request that the Subcommittee postpone mark-up on H.R. 5700 until such hearings are held.

RELATIONSHIP TO THE CONTINUING DISABILITY INVESTIGATIONS

Over the past few years, there has been a change in tone in the disability programs. Without much written instruction, all the signals are that state disability personnel should cut the rolls and keep them small. This has resulted in the termination of severely disabled individuals as well as the denial of new applicants. These signals include:

Requirements that SSA review allowances but not denials or terminations;

Excessive emphasis on speed to the exclusion of accuracy;

As a corrollary, the failure to require states to assure that there be adequate evidence development;

Public discounting by SSA of the currently high ALJ reversal rates, arguing that it is the ALJ's who are out of step with SSA and ignoring the growing problems at the state level;

Statements indicating that SSA is affecting budgetary savings in the disability program by terminating high percentages of allegedly non-disabled persons.

Indicating that the decision regarding which case to review is being based, not upon the likelihood of medical improvement, but upon the amount of the person's monthly benefit (the higher the benefit, the greater the chances for review).

In effect, the Reagan Administration is effecting the budgetary savings in the disability programs by cutting eligible people; exactly what Congress refused to allow them to do just last year.

As other witnesses testifying yesterday and today have established, severely disabled individuals are being terminated without adequate medical evidentiary development and despite the fact that they are totally incapable of working. Often the only documents supporting these arbitrary and incorrect decisions are the inadequate reports of consultative examiners. In some cases, however, cases are being terminated even where the consultative examiner believed the person to be disabled.

All indications are that SSA is concerned with speed, not accurancy, in the disability determination process. That message has been made very clearly in the SSA regulations governing the federal-state relationship. These regulations do not ever require that medical evidence be properly and fully collected. They do, however, set up numerous time frames with which the states must comply. While we agree that the states should be required to operate efficiently, timeliness is not beneficial to claimants and beneficiaries (in the CDIs), if it results in wholesale inaccuracies in decisions. It is similarly not cost-effective for SSA because claimants who do not believe they received full and fair consideration will appeal.

The message must be changed. We propose, first, that SSA be required to amend its regulations to shift the emphasis to assuring accuracy in decision-making at the state level.

To reinforce this shift, SSA should be required to review disallowances in the same fashion that they currently perform pre-effectuation review of allowances. It is not adequate to argue that the ability to appeal the denials is a self-policing mechanism rendering review of disallowances unnecessary. If that was true, SSA would currently be questioning the state's abysmal records rather than attacking the ALJ's high reversal rates. SSA simply does not view ALJ reversals as any reflection upon the accurancy of state agency decision-making. The result is that the easiest, least monitored, route for the states to take is to deny, regardless of the severity of the person's impairments.

In addition to (1) requiring review of disallowances as well as allowances, we recommend that Congress take the following steps to change the message in order to assure that CDIs are performed properly and that claimants receive full protection from SSA and state agency abuses:

(2) Provide aid pending review in the Title II program through the ALJ level and that any payments received during the appeal process will not be treated as an overpayment should the person not ultimately prevail on the merits; and

(3) Amend the definition of disability to clarify that, before a person's disability benefits may be terminated, there must be a showing that his/her medical condition has improved or that the original decision awarding benefits was clearly erroneous. This last point is consistent with the rulings of numerous federal courts, which SSA has illegally chosen to ignore.

CESSATION PROVISIONS OF H.R. 5700

There are a number of provisions in H.R. 5700 which are designed to assist CDI victims in making the transition away from receipt of a monthly disability benefit check. These include: (1) continued benefits for four months if the person has been receiving disability benefits for at least 36 months; (2) expansion of vocational rehabilitation services; and (3) waiver of overpayments created by the back-dating of disability cessation decisions.

While these provisions will be helpful to a few, we are concerned that they are insufficient to meet the CDI crisis and that they reflect incorrect assumptions regarding the effect of the CDI process. First, at least the first two provisions assume that all of the people being terminated are physically able to work. The testimony of other witnesses here, the incredibly high ALJ reversal rates in these cases, and we expect, correspondence from your constituents reflect that this is simply not true. Second, the provisions noted above would only exist through 1984. This assumes that this crisis will somehow disappear. But the crisis will not abate for the thousands of people incorrectly cut from the rolls. Further, given the abusive practices which the CDI program has incorporated (such as inadequate evidence development, failure to monitor consultative physicians, and the use of incorrect standards), it is highly likely that the problem will worsen with time. When considered in conjunction with the H.R. 5700 proposals regarding the reconsideration process, disaster, not improvement, seems most likely.

We believe that the third provision, waiver of overpayments created where the date of cessation precedes the date of the notice of termination, is especially helpful and should be made a permanent provision of the Social Security Act. We are regularly receiving calls from advocates whose clients are faced with a notice of termination which also informs them that, because the date of the cessation has been based upon the date of the beneficiary's visit to the consultative physician, they are also being charged with a four or five month overpayment. We believe that, for some recipients, this combined notice is intimidating and frustrates some people from filing meritorious appeals.

"STRENGTHENING THE RECONSIDERATION PROCESS"

We are very disturbed about the provisions of H.R. 5700 which are intended to strengthen the reconsideration stage of review. Apparently recognizing its current deficiencies, the bill seeks to improve the reconsideration stage. Unfortunately, as currently written, the appellant will bear the entire burden of cleaning up this administrative disaster. Meanwhile, nothing in the bill provides any incentives to either SSA or the states to properly adjudicate cases.

A. Closing the evidentiary record after reconsideration

The vast majority of claimants are not represented at the reconsideration level. They are not familiar with the evidence required to support a finding of disability. Yet, according to H.R. 5700, they alone will bear the burden of assuring that the states improve their evidence development practices. This approach is unrealistic, unfair, and destined to fail.

First, it is unfair to expect that claimants will serve as police officers. The price which they pay is delay. Bouncing back and forth between the federal and state levels will add new elements of delay to the process. The ALJ will be required to review all of the evidence to determine if a remand is appropriate. Then, the case will return to the states, and then back to the ALJ. Our experience has been that very few cases are reversed at the reconsideration level. It is therefore likely that the case will return to the ALJ stage. (While this will initially improve SSA delay statistics at the ALJ level, the cases will eventually return, as well as increased delays created by the two-step process.)

The bill also unfairly shifts an even greater burden onto the unrepresented disabled claimants and beneficiaries to obtain all medical and vocational evidence on their own. The ALJ's will no longer be there to assist and, with rare exceptions, the state levels have not provided that assistance. Nothing in this bill will change that.

Second, it is not realistic to expect that claimant-sought remands will result in a systematic clean-up of the reconsideration stage. Instead, it is more likely that the current problems will simply escalate: stage agencies will deny cases, continuing to provide poor evidence development, knowing that claimants will appeal and, if they can obtain the evidence on their own, be forced to seek a remand. The Congress has already taken steps to remedy an analogous abuse in the SSA appeals procedure: prior to P.L. 96-265, the Appeals Council regularly failed to properly review appeals, knowing that they could easily obtain a court remand if judicial review was sought. There is no reason to create the same problem here.

B. Hearing examiners at the reconsideration stage and showing of prejudice.

Given our general reservations regrading the reconsideration process, we believe that it will be counter-productive to include hearing examiners at the reconsideration stage.

We are also concerned that, unlike ALJ's, these hearing examiners will have no decisional autonomy and will be subject to substantial pressure from SSA, as well as the state agencies, to uphold denials. SSA is attempting to intimidate ALJ's through its perversion of "own-motion" review. There is no reason to believe that state personnel (or SSA district office personnel) designated as hearing examiners will not feel pressures when their pay checks and promotions are deterimed by the same agencies whose decisions they would be reversing.

Under H.R. 5700, in order to appear before a hearing examiner, a person must first make a "showing" that he or she was prejudiced by the intital decision denying benefits. First, it is not clear how an unrepresented person would make that showing. Second, who will decide that a "showing" has been made? These provisions simply create obstacles to a person's right to obtain a full and fair hearing before an administrative law judge.

C. Face-to-face interviews.

We believe that a face-to-face interview with the state agency staff who will adjudicate the claim would be useful. We are concerned, however, with the exception which permits the states to request that SSA district office personnel perform the interview. SSA staff already interview claimants. It is not uncommon for SSA staff to include their observations of the claimant in the file. As these observations currently go unheeded, the exception essentially maintains the status quo and should not be viewed as being of any benefit to the claimant.

"GUIDELINES FOR DISABILITY DETERMINATIONS"

Section 7 of H.R. 5700 would require that ALJs be bound by not only the statute and regulations, but also by the Social Security Rulings (SSRs) and the Program Operations Manual Systems (POMS).

We do not believe that this provision should be enacted. It is critical that the disability determination process and the standards utilized herein be accessible to the public and subject to public comment. We therefore believe that the only binding rules should be those which are properly promulgated in accordance with the Administrative Procedure Act. As will be discussed later, SSA's unauthorized practice of "non-acquiescing" in judicial decisions it disagrees with has effectively insulated it from fully complying with various court rulings, despite SSA's failure to appeal the decision with which it disagreed. The Social Security Rulings, SSA's vehicle for "non-acquiescing," should not be accorded the weight suggested by the proposed provision. Rather, this Subcommittee should examine SSA's policy of "non-acquiescence" and consider its appropriateness in the overall administrative review scheme. As noted later, we believe SSA should be prohibited from disregarding judicial decisions.

Similarly, changes in the POMS are not issued for public comment. The effect of Section 7 will be to encourage SSA to avoid the regulatory process, just amending the POMS. We are already seeing a tendency at SSA to issue Claims Manual sections long before even proposed regulations are issued. This practice should be discouraged rather than encouraged. We can not stress enough the importance of the public comment process. Often, it is the only means available to claimants and their representatives to express their concerns. Finally, access to the POMS is limited to SSA offices, unlike the Code of Federal Regulations, rendering it more difficult to claimants and their representatives to remain up-to-date on its contents.

The section does include language which appears to indicate that the SSRs and POMS need only be followed to the extent that they are consistent with the statute and regulations. If the provision is to be enacted, we support inclusion of this language. However, it must be noted that this does *not* remedy the problems created by the section. Few representatives and even fewer claimants have the easy access to or familiarity with the POMS and SSRs. It is therefore likely that questions of inconsistencies will not be raised.

Further, to the extent that inconsistencies are raised, experience indicates that SSA will ignore ALJ rulings finding such inconsistencies, except with regard to the individual involved, necessitating large numbers of appeals to ALJs, all on the same issue. Exactly this problem occurred with SSA's interpretation of the home resource exclusion in the SSI program. 42 U.S.C. § 1382b(a)(1) was amended in 1976 to provide that the full value of a person's home is to be treated as an excluded resource in determining SSI eligibility. The Secretary took the position that where the person's home generated some income (such as where an elderly person rented a room to a boarder in order to help meet the costs of upkeep of the home), he would continue to apply a $25,000 ceiling on the exempt amount. He did this, not through regulations, but rather through the Claims Manual, predecessor to the POMS. CM T 12600(b). This policy continued until late in 1980, despite rulings by numerous ALJs reversing the Secretary on the grounds that the Claims Manual section violated both the statute and the regulations. And, when SSA did finally change its policy, it refused to apply it retroactively to 1976 when the statute was amended. See Exhibit 1, letter to Eileen P. Sweeney from Robert J. Myers, Deputy Commissioner, Programs (July 2, 1981). Therefore, contrary to Congressional intent, numerous claimants most of whom are not represented and not aware of the POMS, will never benefit from the 1976 amendment. This is true despite the fact that other claimants prevailed on exactly the same issue.

We recognize and share the Subcommittee's concern that there be uniformity at all levels of review. We believe that an alternative formulation of section 7 would adequately meet those concerns while eliminating the problems mentioned above. We therefore recommend that proposed section 7 be amended to require that the regulations of the Secretary, as published in the Federal Register, will govern determinations of whether individuals are disabled at all levels of review.

COURT REMANDS

We find the proposal to eliminate a court's ability to remand, even after a reversal of the Secretary's ruling, very troubling and unwise. [Section 5(c)] In the 1980 amendments, Congress required that remands be permitted only where "good cause" existed. The purpose of the amendment was to address, among others, a bad habit which SSA had: in order to avoid court reversals while also avoiding properly reviewing appeals at the Appeals Council level, SSA would virtually automatically seek remands in meritorious judicial review cases, thereby creating further delay for the appellants.[1]

The 1980 amendments properly addressed an abusive use of the remand. Mr. Pickle has indicated that the number of remands is still high—4,000 in 1981 and that this provision is addressed at eliminating that problem. The proposed solution assumes that there is something inherently bad about remands. That simply is not true. In many cases, a remand is the only relief which will properly remedy the deficiencies in the Secretary's decision. One example will illustrate the problems created. In *Diabo* v. *Secrertary of Health, Education and Welfare*, 627 F.2d 278 (D.C. Cir. 1980), the court held that the ALJ erred in, among others, not ascertaining the severity or effects of the pain which Mr. Diabo experienced, nor the effects of the medication which the claimant was required to take. The court also held that the ALJ incorrectly omitted necessary information from the hypothetical question he provided to the vocational expert regarding the availability of jobs which Mr. Diabo could perform, 627 F.2d at 282–3. As a result, the court "vacated and remanded" the case, and, "[i]n view of the seven years already consumed in this case, . . . urge[d] the Secretary to proceed speedily." Id. at 283. Mr. Diabo was unrepresented at all levels before judicial review.

If the court had not been able to remand this case to the Secretary, what could it have done with it? Elimination of the ability to remand will create a class of claimants whose cases will be in limbo. Despite the fact that the Secretary's decisions have been reversed or vacated, they will not be able to provide the additional information required to make a correct decision, so they will never receive benefits.

It would not have been proper for the *Diabo* court to simply reverse the Secretary and reward Mr. Diabo benefits. The bases for the reversal were various omissions in facts and incorrect assumptions and statements by the ALJ which rendered the vocational expert's testimony useless. Without the omitted information and properly-based expert opinions, there is no way that the court could determine the ultimate outcome. If there is no remand, its only recourse would seem to be to refer the case back to the district court in order to accept and review new evidence. This would not seem to be a desirable result.

SOCIAL SECURITY COURT

A. The court is not needed

Creation of a "Social Security Court" is unnecessary and essentially rewards SSA for its years of arrogant disregard of court rulings as well as substantial involvement in creating delays in the resolution of cases on judicial review. Mr. Pickle cited both the problem of SSA "non-acquiescence" in court rulings and the delays in federal courts as the grounds for creation of such a court. It would be more appropriate for the subcommittee to investigate SSA's practices in these two areas and consider steps to require SSA to make the current system work.

1. Delays in federal court.—First, it must be recognized that for the vast majority of OASDI and SSI appellants, the most serious delays occur at the administrative level. It is not uncommon for appellants to experience delays of up to six months at the reconsideration level alone. And, SSA has done everything in its power to assure that delays will continue at the ALJ level. In *Blankenship* v. *Secretary of HHS*, Civil No. C75-D185L(A) (W.D. Ky.), after seeking to expand the time frame to 165 days (5½ months) at the ALJ stage, SSA is now attempting to avoid even this excessively long time frame. Further, months can be spent at the Appeals Council level. Very few of these cases are appealed to federal court. In 1981, there were an estimated 238,171 appeals at the ALJ Level,[2] while there were only 9,043 appeals to federal district court for the twelve month period ending June, 30, 1980.[3] Therefore, while we are concerned that there are delays in the federal courts, for most people that is not the greatest source of delay.

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[1] "In addition to concern about the growth of the courts' workload and adherence to the substantial evidence rule, concern has been expressed about the Secretary's authority, on his own motion, to remand a case back to an ALJ prior to filing his answer in a court case.

"Some critics have suggested that such absolute discretion gives the Secretary potential authority to remand cases back so that they can be strengthened to sustain court scrutiny. Others have suggested that such a device also may have the tendency to lead to laxity in appeals council review in that it will give the council another look at the case if the claimant decides to go to court." Senate Report No. 96-408, p. 58, [1980] U.S. Code Cong. & Adm. News 1277, 1336.

[2] "Affidavit of Louis B. Hays" in *Blankenship*, supra, p. 3, filed December 1981.

[3] 1980 Annual Report of the Director, Administrative Office of the United States Courts, table 39, p. 74.

Second, it is critical to recognize that SSA is often the source of the delay in federal court. All too frequently, we see the Assistant U.S. Attorney sheepishly explaining to a court that he/she needs an extension of time because his/her client, the Secretary, has not provided the answer or other required materials for filing. In the federal district courts for the Northern District of California, the courts have apparently tired of such motions and now routinely defer to the Secretary: as soon as a complaint is filed, regardless of the issue and without the Secretary having to file a motion, an order issues granting him an extension of time. See Exhibit 2, attached.

In a disability case in the Southern District of Florida, when the appellant's attorney opposed the Secretary's request for an extension (filed in 1980), the U.S. Attorney filed a four-year old memo from SSA in Baltimore attempting to justify the need for extensions of time in which to file answers by describing the administrative delays which result at various steps, once judicial review is sought. [Letter from Randolph W. Gaines, Chief of Litigation, Office of General Counsel, HHS to Rex E. Lee, Assistant Attorney General, Department of Justice, Civil Division, dated November 13, 1975, filed in *Genovese* v. *Harris,* No. 79-8345-Civ-NCR (S.D. Fla.), attached as Exhibit 3] According to the memo, the following average time frames existed in 1975:

6.5 days for the U.S. Attorney to be served after a complaint is filed;

13 days after that for the Bureau of Hearings and Appeals to be told of the suit;

40 days after that "before the completed transcript is forwarded to the Reprographic Unit." (Details of activity during that period are included.);

There is no estimate of the time it takes to copy the record: "The printing process also has caused some delay. At present, the Reprographics Unit has the capacity of making 2300 plates (pages) per day without overtime. However, the current caseload from the Bureau of Hearings and Appeals far exceeds 2300 pages per day, and a backlog has been created." (page 2);

Then there is additional time required to draft a recommended answer; and

The recommended answer is then mailed to the U.S. Attorney where it is put in final form. "Mailing time is of course also a factor . . ."

While we are not comfortable relying upon 1975 data, we note that this memo was filed by the government with a federal district court in 1980. Also, given the increased number of actions for judicial review filed in recent year, it is likely that the situation has deteriorated even further.[4] We would therefore suggest that before creating a new court structure, it would be less expensive to investigate the real causes of federal court delay and, if appropriate, require SSA to expand its capacity to address these cases. For example, acquisition of another of a more efficient copying machine apparently could make a big difference here.

It should also be noted that because SSA is often the source of the delays in federal court, it is likely that exactly the same problems will exist if the new court is created: SSA's copying machine will not work any faster. Further, any suggestion by SSA that it would be able to work more efficiently in addressing cases filed before a new court should raise serious questions regarding what effort it has made to reduce delays under the current scheme.

2. SSA policy of "non-acquiescence" in federal court rulings.—We addressed this problem in some detail in our testimony before the subcommittee in October, 1981.[5] We will therefore only summarize the material and provide an update of SSA's practices. First, SSA has developed the nasty habit of ignoring rulings of the United States Courts of Appeals. They do so despite the fact that they have specifically informed the United States Supreme Court that their policy is the exact opposite. In *Califano* v. *Yamasaki,* 442 U.S. 682, (1979), the Secretary argued that certification of class action was not necessary because he followed rulings of the Circuit Courts of Appeals.[6]

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[4] It should be noted that while there has been an increase in the number of cases on judicial review, the numbers have recently begun to drop. 1975, 5,846; 1976, 10,355; 1977, 10,095; 1978, 9,950; 1979, 9,942; 1980, 9,043. 1980 Annual Report of the Director, Administrative Office of the United States Courts, table 29, p. 74.

[5] "Social Security Appeals and Case Review Process," Hearings before the Subcommittee on Social Security of the Committee on Ways and Means, October 23 and 28, 1981, serial 97-31, pp. 200-209, in particular pp. 206-207.

[6] "Restricted judicial review willnot have a detrimental effect on the administration of the Social Security Act, the Secretary says, because he will appeal adverse decisions or abide [by]

Despite these representations to the Supreme Court, to which that Court specifically referred, SSA's true policy is that it will only follow decisions of the Supreme Court. A memo from Louis B. Hays, Associate Commissioner of the Office of Hearings and Appeals, to all ALJs, dated January 7, 1982, specifically states:

"Frank Dell'Acqua [Deputy Assistant General Counsel, Social Security Division] stressed that point that the federal courts do not run SSA's programs, and that ALJs are responsible for applying the Secretary's policies and guidelines regardless of court decisions below the level of the Supreme Court. . ." (p. 2)

But, despite the fact the Secretary frequently loses cases in the Courts of Appeals, he rarely appeals. Conveniently, under his policy, because he does not appeal to the Supreme Court, there will not be a Supreme Court decision which he would have to follow. This means that he can simply award the named plaintiff benefits while otherwise ignoring the case.

A problem currently existing in the Ninth circuit is an excellent, well-documented example of this incredible problem. In *Finnegan* v. *Mathews*, 641 F. 2d 1340 (9th Cir. 1981), the Ninth Circuit ruled that the secretary could not terminate the benefits of SSI disability recipients who had been "grandfathered" into the program from state disability rolls when the SSI program began, unless SSA established that either the "recipients' medical conditions has materially improved" or that there was "clear and specific error" in the original finding of disability. In other words, SSA can not apply its current regulations to cut a grandfathered person off as that would defeat the underlying purpose of the grandfathering language of the SSI provisions.

SSA did not like the *Finnegan* ruling. But, unlike other disgruntled litigrants, it decided not to appeal to the Supreme Court and, instead, "non-acquiesced"in the ruling. SSA's thought processes here are particularly instructive. In a September 14, 1981 memo from Sandy Crank, Associate Commissioner for Operational Policy and Procedures, to Donald A. Gonya, Assistant General Counsel (attached as Exhibit 4), Sandy Crank outlined the following reasons for not appealing:

(1)". . . according to our review of the medical evidence in file, it is questionable whether Finnegan is in fact not disabled at this time." (page 3) Simply put, SSA had defended the Secretary's termination of benefits all the way through the Ninth Circuit, despite the fact that even they believed that Mr. Finnegan was disabled.

(2) "Mistakes were made in the legal defense of this case before the Court of this case before the Court of Appeals." (page 3)

He then recommended that SSA "non-acquiesce" in the court's order and wait for a case with poorer facts to take to the Supreme Court:

"With a nonacquiescence ruling, we can attempt to argue this issue again before the courts in a case in which the plaintiff is clearly not disabled, where the State disability determination is in fact not available and where the case can be prepared properly without the legal flaws found in *Finnegan*. The Office of Hearings and Appeals agrees with this course of action." (Id.)

So, in January, 1982, SSA issued Social Security Ruling 82-10c, "non-acquiescing" in *Finnegan*. And, as if that was not sufficient, on February 23, 1982, Louis B. Hays wrote another memo to all ALJs, specifically telling them that they were bound by the Social Security Rulings and were to ignore *Finnegan* even in "cases involving claimants who reside within the jurisdiction of the United States Court of Appeals for the Ninth Circuit." (Exhibit 5)

This practice is clearly illegal. At least two circuit courts of appeals have struck a virtually identical practice of the National Labor Relations Board. See, for example, *Ithaca College* v. *NLRB*, 623 F. 2d 244 (2d Cir. 1980); *Allegheny General Hospital* v. *NLRB*, 608 F. 2d 965 (3d Cir. 1979). These cases hold that the agency is bound to follow the law of the circuit. Failure to do so results in the agency operating "outside the law." *Allegheny General Hospital*, 608 F. 2d at 970.

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them within the jurisdiction of the courts rendering them." 442 U.S. at 699. In its Brief for the Petitioner in *Yamasaki*, at pp. 68-69, the Secretary specifically stated:

"Contrary to the fears of the courts of appeals that have endorsed class actions under (§ 405(g)), the restricted version of judicial review permitted by that statute will have no detrimental effect on the efficient resolution of Social Security Act claims. When a statutory or constitutional issue is decided adversely to the Secretary in the course of judicial review obtained by an individual claimant, *the Secretary will either appeal or abide by the unfavorable ruling*. See *Philbrook* v. *Glodgett*, 421 U.S. 707, 720-772 (1975). Repetitious litigation will thus not be necessary in order to establish a general legal principal applicable beyond the confines of a particular case. (At this point, a footnote adds, "In some cases, however, additional litigation of an issue in additional jurisdictions is desirable. See pages 75-76, infra.) Stare decisis will impel the Secretary to follow statutory or constitutional decisions within the jurisdiction of the courts having rendered them." [Brief for the Petitioner (Secretary of the Department of Health and Human Sevices) at 68-69, *Califano* v. *Yamasaki*, supra (emphasis added)].

SSA's illegal practice, just in the *Finnegan* case, resulted in the filing of additional litigation, all of which must be defended at government expense. In the state of Washington, a class of grandfathered SSI recipients who have been terminated have sued to enforce *Finnegan*. *Siedlecki* v. *Schweiker*, No. 82-61R (W.D. Wash.) It is likely that other such cases will be filed in the states within the jurisdiction of the Ninth Circuit. In addition to needless governmental expense, SSA's failure to follow *Finnegan* has resulted in the cessation of hundreds, perhaps thousands, of SSI grandfathered recipients who are clearly entitled to benefits and who have no other means of support.

We stress that the *Finnegan* case is just one example of this problem.[7] Given SSA's blatant flaunting of the law and its clearly stated misrepresentations to the Supreme Court, it is hard to believe that the Congress' solution will be to embrace the Secretary's consistently illegal practices as a justification for the creation of a new court. It would be much more preferable to require SSA to follow the law for a few years and then assess whether there is a need for such a drastic measure as a new court.

B. Review of the H.R. 5700 Social Security Court provisions

If the Congress does determine to establish a new court system, we believe that there are serious deficiencies in the current proposal.

1. Independence of the court.—We are concerned both about the quality of decision-making and the independence of such a court. Given that the vast majority of cases coming before the court will concern disability claims, we are concerned that it may be difficult to attract judges of the same calibre as those on the federal bench and that the lack of variety will result in such routinization of case review that the court will eventually become nothing more than a "rubber stamp" for the Secretary; in effect, a new Appeals Council. As this Subcommittee is well aware, Social Security and SSI benefits are of critical importance to millions of Americans. The federal district courts have been, on the whole, sensitive and invaluable protectors of the rights of Social Security claimants. We believe that such sensitivity will be lost if a specialized court is created.

2. Applicability of the Federal rules of civil procedure.—It appears that the bill would remove the court from the coverage of the Federal Rules of Civil Procedure, providing that the proceedings of the court "shall be conducted in accordance with such rules of practice and procedure as the Court may prescribe." Section 1130(e)(1). Given SSA's failure to implement judicial rulings to the benefit of all similarly situated to an individual plaintiff unless a class has been certified pursuant to Fed. R. Civ. P. 23 (see discussion of SSA's practice of "nonacquiescence"), it is critical that the ability to seek class relief be retained. Provision of class relief both reduces the number of cases which must be filed on identical issues and increases the uniformity of decisions made at the administrative levels. We therefore recommend that the court be bound by the Federal Rules of Civil Procedure.

3. Filing fees.—Section 1130(f)(5) authorizes the Court to charge filing fees, "except that any fee so fixed may be waived by the Court in any case upon a determination that the imposition of such a fee would cause hardship to a claimant." While the general "hardship" language should be retained, automatic waiver should be created for the following groups, any time that the basis for the Secretary's denial, termination, or reduction in benefits was for reasons other than excess income or resources:

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[7] For other examples, compare: *Levings* v. *Califano*, 604 F. 2d 591 (8th Cir. 1979), with Social Security Ruling (SSR) 80-11c; *Boyland* v. *Califano*, CCH Unempl. Ins. Rptr. ¶ 16,912 (6th Cir. 1980), with SSR 81-1c; *Rasmussen* v. *Gardner*, 374 F. 2d 589 (10th Cir. 1967) with SSR 68-48c. This list is by no means exhaustive. Even where SSA has not issued a ruling refusing to follow a court's order, it has frequently done just that, ignoring others similarly situated until another court requires it to address the class aspects of the issue. For example, the district court's failure to certify a class in *Wiesenfeld* v. *Secretary of Health, Education and Welfare*, 367 F. Supp. 981, 986-987 (D.N.J. 1973) (three-judge court), which invalidated a gender based classification in the Social Security Act, resulted in the need for additional litigation. First, the Secretary refused to provide relief to anyone but the named plaintiff until the Supreme Court issued its decision affirming the three judge court's ruling. 420 U.S. 636 (1975). Second, after that ruling, the Secretary applied the decision only prospectively to other individuals. At least two other suits were filed in order to obtain the benefits for the period prior to the Supreme Court's decision. See *Crumpler* v. *Califano*, 443 F. Supp. 342 (E.D. Va. 1978); *Hurvich* v. *Califano*, 457 F. Supp. 760 (N.D. Cal. 1978). A similar situation arose after the Supreme Court struck down another gender-based classification in the Social Security Act. See *Califano* v. *Goldfarb*, 430 U.S. 199 (1977). Shortly thereafter, the Supreme Court summarily affirmed three district court rulings holding unconstitutional the same provision. At that point, the Secretary took the position that he would only pay benefits to those few individuals injured by the provision who had received a final adverse decision from the Secretary and also instituted suit against the Secretary pursuant to 42 U.S.C. § 405(g). *Wright* v. *Califano*, 603 F. 2d 666, 668 (7th Cir. 1979). It was not until the Seventh Circuit's ruling in *Wright*, supra, that the Secretary finally agreed to pay all the benefits due to all individuals who had been injured by the provision held unconstitutional in *Goldfarb* who were members of the certified class in *Wright*.

(1) SSI beneficiaries;
(2) SSI applicants;
(3) applicants for and recipients of concurrent benefits (OASDI and SSI); and
(4) all OASDI beneficiaries or applicants whose income level will be or is not higher than the SSI benefit level, taking into account the SSI $20 income disregard.

While there will be others who should be permitted to prove that they meet the "hardship" exception, individuals falling in all of the categories above are, by definition, extremely needy.

Automatic waiver will have a number of favorable results: (1) it will eliminate a potential obstacle to seeking review for the appellant; (2) it will greatly reduce the paperwork both for the court and the appellants; and (3) it will assure that inappropriate considerations, such as the financial health of the court, do not enter into the waiver decisions. Further, it will send a message to the court that, given the general characteristics of the population filing appeals, waivers are to be liberally granted.

4. Limitations on appeals from the Social Security court.—Section 1130(g) would limit appeals so that they may be heard by the United States Court of Appeals for the District of Columbia and, then, review is restricted "to questions of statutory interpretation and constitutional issues." The geographical limitation will reduce the number of appeals taken on meritorious issues, as claimants will either not have access to the District of Columbia Court of Appeals or will perceive that they do not. Wealthy claimants will be the best situated to file such appeals as they will be able to pay for the attorney's travel costs or the most likely to know how to secure counsel in the District. We suspect that the geographical limitation, much like the court itself, will reduce the public's (and the claimants') perception of the fairness of the system.

The limitation upon the issues which may be appealed effectively insulates the Court from review of the vast majority of its decisions. We do not think that this is a healthy result and find the parallels to the insularity of the Board of Veterans Appeals frightening. There, the absence of effective review (limited solely to constitutional issues) has resulted in incredible arbitrariness and the denial of eligibility to substantial numbers of individuals clearly eligible for benefits. We encourage the Subcommittee to eliminate this restriction on appeals and to also provide for appeals to all of the Circuit Courts of Appeal, based upon the residence of the appellant.

5. Ability of appellants to appear at hearings; expenses.—Currently, there are over 75 federal district courts in which a petition for judicial review may be filed and 516 federal district court judges to review the cases. The bill will reduce the number of judges to 20 [section 1130(c)(1)], permits the court to "sit at any place within the United States" [Section 1130(d)(4)], and instructs the chief judge to schedule court sessions at such "times and places" as will "secur[e] reasonable opportunity to claimants to appear before the Court or any of its divisions with as little inconvenience and expenses as is practicable." [Section 1130(d)(5)]

It is unlikely that 20 judges, even if they have 20 "commissioners", will be able to hold sessions in as many places as the federal district courts with their 516 judges. In some areas of the country, the federal district courts are already at least a few hours away from claimants' homes.

If the new court is created, it must be recognized that there will inevitably be a reduction in access to judicial review and, most likely, further decline in the public's confidence in the fairness of the Social Security system. Further, the language of the bill appears to anticipate that appellants, the majority of whom are poor people, will be the ones who bear the burden of the "inconvenience and expense." We believe that the bill should require the Court to reimburse or, if needed, make prior payment for necessary travel expenses related to actively pursuing their claims before the court.

6. Priority for Title II cases in the transition period.—While we are opposed to the creation of the court, and, thus, to the need for a transition period, if there is a transition period, providing Title II (OASDI) cases "preferred cause" status is desirable. [Section 12(f)(2).] However, two points should be noted. First, we are not aware of the existence of any parallel provision providing preferred cause status to SSI cases. If it does not exist, the provision should be amended to cover SSI cases as well. Second, unless the SSA takes steps to improve its operations (see discussion above), it is not likely that providing "preferred cause" status will substantially improve the delay problem.

PAYMENT FOR CONSULTATIVE EXAMINATIONS/VOLUME PROVIDERS

We believe that this portion of the bill is intended to address the subcommittee's concerns about the use of volume provider consultative physicians. While the provisions proposed will be useful, they are not sufficient to address the incredible problems which exist with volume providers in particular but also many other consultative physicians as well.

The federal government paid approximately $137,400,000 for consultative examinations in 1981.[8] That figure will increase if the Medicare Part B rates proposed in H.R. 5700 are utilized. It is therefore reasonable to assume that SSA should be expecting to get something useful for its money.

In some areas of the country, the administrative law judges simply ignore the consultative reports because their experience with the particular provider(s) has taught them that their reports are useless and unreliable. Given the current abuses of some consultative physicians, that is as it should be. However, it is critical that the cost implications be recognized. Because SSA has failed to regulate consultative physicians, it is throwing money away just so that it can assure that there is a piece of paper in the file. If the reports are so useless as to be ignored, they should not be purchased. It is critical that SSA be required to issue regulations which set forth minimum requirements for consultative physicians.

Given the immediacy of the problem and SSA's history of failing to address it, it is not appropriate for the Congress to defer the issue to the Advisory Council for further study. SSA should be directed to issue regulations immediately and be required to monitor, either directly or through the states, the adequacy of consultative examiners on a number of factors. The factors proposed by Dr. David A. Ketroser, a volume provider, on March 11, 1982 at the joint hearing of the Oversight and Social Security Subcommittees on the volume provider problem should be carefully considered. He proposed:

A. All claimants should be examined by a physician who does the entire history and physical examination;

B. There should be no more than 2 patients seen per hour for Internal Medicine, Neurology, or Psychiatry, and no more than 2 to 2.5 for Orthopedic Surgery;

C. Physicians should evaluate patients in their area of expertise;

D. Stress testing should be done by physicians trained in cardiology who are in the stress testing room at all times, not just in the office;

E. X-ray testing should be done using fixed, non-mobile equipment. X-rays should be read either by a radiologist or an orthopedic surgeon; and

F. The examining facility should be examined by the state agency both before operations begin and at least annually thereafter on an unannounced basis.

In addition, we believe that there should also be regulation and monitoring of the following:

G. Minimum competency requirements for technicians, aides and paramedics working with consultative physicians;

H. A requirement that the consultative physician personally author and sign the report and the physical capacities evaluation;

I. A requirement that the state unit consider paying for a consultative exam performed by the claimant's treating physician before considering a referral to a non-treating physician;

J. A requirement that the State Disability Determination Unit establish contacts with community health clinics to assure that more consultative exams are performed locally instead of by volume providers; and

K. The regulations should also establish some mechanism for assuring that claimant complaints regarding consultative physicians are investigated and resolved.

Two provisions of H.R. 5700 do address a portion of the problem, but as previously noted, nothing in the bill attempts to solve any of the problems previously mentioned. Section 16 of H.R. 5700 provides that the fees for consultative examinations will be set at 100 percent of the prevailing charge under Medicare Part B. This is a reasonable response to the concerns of state disability personnel that the fees, now determined by each state, are often too low to attract physicians other than the volume providers.

The provision would also require that SSA contract with one carrier to pay all consultative examination fees. As long as the carrier acts "efficiently and effectively," as required in H.R. 5700, utilization of one carrier should permit SSA to easily identify the volume providers and, possibly, abuses. However, if the carrier delays in reimbursing physicians, it is likely that, regardless of the increased fees, non-volume provider physicians will continue to avoid these cases.

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[8] Statement of Sandy Crank, Associate Commissioner for Operational Policy and Procedures, Social Security Administration, Sept. 18, 1981, hearing on volume providers, serial 97-27, p. 12.

CREATION OF THE ADVISORY COUNCIL ON THE MEDICAL ASPECTS OF DISABILITY

We believe that the Secretary is desperately in need of assistance in addressing many of the topics listed as topics of concern for the Advisory Council. While we are not sure that creation of the Council is needed, if it is to be created, we believe that its membership composition must be realligned if it is to properly address the topics listed. As currently composed, we do not believe that it will reach valid decisions.

As proposed in the bill, there will be 15 members of the Council: 4 medical association slots (Association of American Medical Colleges; American Medical Association; American Osteopathic Association; National Medical Association); 8 individuals related to the state disability decisionmaking process (state disability agency administration, physicians and osteopaths "employed by or under contract with such State agencies," and consultative physicians; however one designeee must be from the National Association of disability Examiners or the Council of State Administrators of Vocational Rehabilitation); and 3 individuals "who are outstanding in fields related to hospital, medical, and other health activities."

A review of the tasks to be undertaken by the Council suggests that there should be far more than three individuals "who are outstanding in fields related to hospital, medical, and other health activities" and probably none from the category providing for 8 state level individuals. The functions are discussed below:

A. Assist in the development of courses of instruction on the medical impairments: A representative from the Association of American Medical Colleges does seem to be appropriate here.

B. Evaluate and make recommendations concerning continuing education programs: Here, all four of the general medical associations could potentially be useful.

C. Evaluate the process of procuring medical evidence and establish standards governing the purchase of independent medical examinations: For this group to be useful, it must have some independence and detachment from the state procedures. If 8 of the 15 members are connected to the state units, it is very likely that the recommendations will be skewed. It would seem more appropriate for a panel of experts to have state-level people make presentations to it rather than having the state-level people making the recommedations. This is particularly true in light of the serious problems currently existing at the state level.

D. Advise the Secretary as to the proper level of medical documentation needed for adequate adjudication of claims: While we are pleased to see this issue becoming a matter of concern, this issue probably more than any other, clearly demonstrates the problems with the composition of the Council. Almost all of the states and consultative physicians currently provide far less than a proper level of medical documentation. It is absurd to have a Council which includes a majority of such individuals making recommendations on this issue. It would be far more helpful to have a panel of Medical experts assess various types of impairments and then make recommendations on this topic.

E. and F. Advise on the listings of Impairments and examine the feasibility of making disability awards on a time-limited basis: None of the state administrative people are properly experts on these issues. It would be much better to request that a panel of physicians specializing in various areas make these recommendations.

G. Advise the Secretary on "matters of general policy" with respect to disability determinations under Title II: While some of the state unit people may be appropriate members of a group to address these issues, there are many other voices which should also be heard. These include administrative law judges; local SSA district office staff; disabled people, possibily represented through organizations concerned about their interests; and attorneys representing Social Security claimants and beneficiaries.

CHANGE IN THE RECENCY OF WORK TEST

The change in the recency of work test in Section 9 must be recognized for what it is: a cut in eligibility for benefits. The current test, five out of the last ten years, adequately addresses Congressional concerns that disability insurance benefits only be available to meet the expectation of income lost as a result of disability.

We have heard that the subcommittee estimates that the provision will result in the denial of benefits to between 600 to 2,000 disabled people annually. If these low figures are correct, it's very difficult to understand why the provision is even being proposed. However, we believe that the figures are actually much higher. The provision will hurt individuals who tended to have very spotty work records immediately prior to the official onset of their disability (but who had previously worked enough in covered employment to be otherwise eligible for benefits). Often, the person's disabling impairment will be the cause of the spotty work record. This will be particularly true for people with mental impairments and those with dengenerative diseases.

In addition, it is likely that this will create just one more barrier to women receiving an adequate return on their investment in the system. Changing the recency of work test will disadvantage parents (usually women) who have left the work force temporarily to care for their young children.

ATTORNEYS' FEES

A. Deregulating attorneys' fees

H.R. 5700 would deregulate attorneys' fees, removing SSA from the process. We understand that while the private bar would not mind losing SSA's delays, they are concerned that back award checks be addressed to both the claimant and the attorney.

We believe that the attorneys' fee provision, set forth at 42 U.S.C. § 406, should be maintained. However, steps should be taken to rectify specific problems in the administration of the fees provision so as to encourage the private bar to represent Social Security claimants.

First, private attorneys representing claimants regularly complain that the delays in payment by SSA are so long that they are unable to rely upon the fees in projecting their offices' income. SSA should be required to expedite the payment of fees within an established, predictable time frame. Requiring expeditious payments would also benefit claimants. Before SSA pays a back award where a claimant was represented, it routinely withholds the full 25 percent, the maximum fee permitted under § 406. Often the fee awarded is less than 25 percent. Expeditious payment of fees to attorneys should result in SSA also paying claimants the remainder of their awards in a more timely fashion.

Second, while 20 C.F.R. § 404.975 (b) and (c) provide to the contrary, private attorneys have indicated that SSA subtracts any workers' compensation offset before it determines the amount of the back award which is the basis for the attorney's fee. This results both in smaller fees and a great deal of unpredictability as to the possible amount of the fee award, discouraging the private bar from accepting the cases. A similar problem results from the requirement of P.L. 96-265 that SSI payments made to a Social Security claimant be subtracted from the Title II back award. Steps should be taken to assure that SSA complies with the requirement of 42 U.S.C. § 406(a) that the fee will be taken from the "total amount of such past-due benefits." Deregulation of attorneys' fees will not eliminate this problem as SSA will make all SSI and workers' compensation deductions prior to issuance of the check.

If a decision is made to deregulate fees and if the private bar prevails on the issue of jointly-drawn checks, we suggest:

(1) The statutory maximum of 25 percent of the back award should be retained, and

(2) To avoid unnecessary hardship for claimants, who often have incurred substantial debts while awaiting payment of benefits, SSA should be required to cut two checks: one for 75 percent to be sent directly to the claimant, and the other for 25 percent to be addressed jointly to the claimant and the attorney.

B. Equal Access to Justice Act

We oppose elimination of fees under the Equal Access to Justice Act. The Act is based on the premise that Americans of limited means who come into legal conflict with the federal government are severely disadvantaged by the immense resources of the government. It provides that the government itself must pay the fees incurred by parties who prevail against it. However, the government is only liable when it cannot persuade a court that its position in the litigation was "substantially justified".

SSA's non-acquiescence practices appear to be an excellent example of the type of situation where fees should be awarded. Unfortunately, protecting SSA from payment of such fees will once again just reward SSA for its illegal practices and signal Congressional approval.

The Act did not take effect until October 1, 1981. There is currently no SSA track record under the Act. We recommend that the Subcommittee not act on this matter at this time and, instead, require SSA to submit a report to the Congress by January 1984 setting forth the cases where such fees have been sought, the issues in the underlying case, and the resolution of each such fee petition.

Thank you for this opportunity to testify.

[Attachments]

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., July 2, 1981.

MS. EILEEN P. SWEENEY,
Attorney at Law, National Senior Citizens Law Center,
Washington, D.C.

DEAR MS. SWEENEY: Please accept my apology for the delay in responding to your letter of November 7, 1980 concerning the home resource exclusion in the supplemental security income (SSI) program.

As you are aware, the SSI program contains criteria regarding the amount of resources an individual can have and still be eligible for payments. The statute provides some exclusions from resources, and one exclusion applies to an individual's home, and another to property essential for self-support, subject to limitations prescribed by the Secretary. In January 1974, we decided that if property essential to self-support is associated with an individual's home, it could be excluded if the value of the home and income-producing assets together did not exceed $25,000 ($35,000 in Alaska and Hawaii). This policy recognized the fact that in many cases the income-producing assets were closely associated with home property and not easy to evaluate.

We have reexamined our policy and decided to change it so that we evaluate the individual's income-producing assets separately from the home. Thus, an individual's home which has an income-producing activity associated with it will be excluded regardless of the value of the home, and the other income-producing assets will be evaluated separately. The consistent treatment of the value of the home in all SSI cases was an important consideration during our policy review.

Since we changed our position on this particular policy, the instructions in claims manual (CM) 13766 apply. A determination may be revised only when it has been questioned in writing within one year from the date of the notice of initial determination, and (1) this questioning takes place after the change-of-position occurs or (2) the claim is pending when the position is changed. Otherwise, the change-of-position has prospective effect only.

It is important here to emphasize the fact that we have not changed any existing regulations; rather, we have reinterpreted our operational policy. Therefore, CM 13767 does not apply because those operating instructions state that when a change in statutory or regulatory provision occurs, reopening of prior determinations will depend on the provision of the amendment itself.

With respect to the exclusion of the home, 20 CFR 416.1212, as amended to implement the 1976 amendment to section 1613(a)(1) of the Social Security Act, provides an effective date of October 1, 1976. This regulatory amendment was published August 9, 1977 and no other regulatory changes have been made regarding these policies.

Determinations involving ownership of a home associated with an income-producing activity, however, do not fall within the purview of this particular regulatory amendment. The first operating instructions implementing this amendment adopted a restrictive interpretation of the statute regarding treatment of the home when an income-producing activity is associated with it. The elimination of this restriction was the result of a reevaluation of prior operating policies. Therefore, claims denied because of the policy on income-producing property associated with the home will be reopened (if appropriate) only under the rules of administrative finality.

We issued a teletype (IT-147-80) on August 1, 1980 informing our operating personnel that a change was pending and instructing them to keep a list of all cases terminated or denied solely on the basis that the value of the home and associated income-producing assets exceeded $25,000 ($35,000 in Alaska and Hawaii). Subsequently, we issued the change of position regarding income-producing property in a September 26, 1980 teletype (IT-181-80). All SSI claims which come to our attention after this date will be reopened if the claimant questions the decision within one year of the date of notice of the initial determination. Claims manual instructions have now been sent to our local offices.

We provided incorrect information to Bruce Hagel in our October 9, 1980 response to him. Cases will be reopened only if the procedure described in the preceding paragraph is followed. I am sending a copy of this letter to Mr. Hagel in order to clarify our position.

Sincerely,

Robert J. Myers,
Deputy Commissioner (Programs).

[U.S. District Court for the Northern District of California, Case No. C 80 3959]

PROCEDURAL ORDER FOR SOCIAL SECURITY REVIEW CASES

To parties and counsel of record in the above action: The above action seeks review of a decision by the Secretary of Health, Education and Welfare denying plaintiff Social Security disability benefits. The Court's jurisdiction is limited to reviewing the administrative record to determine whether the decision is supported by substantial evidence in the record. Good cause appearing, it is hereby ordered:

1. Defendant shall serve and file his answer, together with a certified copy of the transcript of the administrative record, within ninety days of the date of this order.
2. Plaintiff shall serve and file a motion for summary judgment or for remand within thirty days of service of defendant's answer.
3. Defendant shall serve and file his opposition and counter-motion for summary judgment within twenty days of service of plaintiff's motion, or fifty days after answer, whichever is later.
4. Plaintiff may serve and file a response to defendant's opposition and counter-motion within ten days of service of defendant's opposition and motion.
5. The matter shall be deemed submitted fifteen days after filing of defendant's opposition and counter-motion without hearing, unless otherwise ordered by the Court.
6. No extensions of time will be permitted without order of the Court.

For the Court:
William L. Whittaker, *Clerk.*

[U.S. District Court, Southern District of Florida, Case No. 79-8345-Civ-NCR]

JOSEPHINE GENOVESE, PLAINTIFF, VERSUS PATRICIA HARRIS, SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE OF THE UNITED STATES OF AMERICA, DEFENDANT

MOTION FOR EXTENSION OF TIME

Comes now the United States Attorney, counsel for Defendant herein, and moves this Honorable Court for an Order extending the time an additional sixty (60) days until March 20, 1980 to answer or otherwise plead, and as reason therefor says that Defendant is required to file a transcript of administrative proceedings as a part of its answer and that such transcript will not be available by the date on which the answer is due for the reasons set forth in the attached letter from the Department of Health, Education and Welfare.

I hereby certify that a true copy of the foregoing Motion for Extension of Time was mailed this 11th day of January, 1980, to Florida Rural Legal Services, Inc., per Donald W. Miles, Esq., Room 408 Citizens Building, 105 South Narcissus Avenue, West Palm Beach, FL 33401.

Respectfully submitted,

J. V. Eskenazi,
U.S. Attorney.

Department of Health, Education, and Welfare,
Baltimore Md., November 13, 1975.

Re Explanation of need for time extensions in answering complaints under Titles II, XVI, XVIII of the Social Security Act and the Federal Coal Mine Health and Safety Act cases.

Hon. **Rex E. Lee,**
Assistant Attorney General, Department of Justice, Civil Division, Washington, D.C.

Dear Mr. Lee: The purpose of this paper is to clarify the bases of requests for extensions of time to answer in litigation under Titles II, XVI, XVIII of the Social Security Act and Part B of the Federal Coal Mine Health and Safety Act of 1969 as amended. Such litigation involves the review of final decisions of the Secretary of HEW which are based, in almost every case, on records of hearings held by the Bureau of Hearings and Appeals of the Social Security Administration as well as medical and non-medical exhibits. The need for time extensions is caused by the increasing caseload and the time required to compile and reproduce transcripts for these cases.

The compilation of the administrative transcript is itself a very time-consuming process. Overall, a large majority of all claims are allowed administratively. Of those finally denied only a small percentage become the subject of litigation. Therefore, in order to conserve both time and money, the complete transcript of the record as required to be filed in court with the Government's answer under 42 USC 405(g) is ordinarily not compiled unless and until litigation is instituted following a final administrative decision. Earlier preparation of such transcripts would obviously be wasteful. As a consequence, after the action has been filed, the testimony and the exhibits must be transcribed and assembled, and after the record has been put together, printed or photocopied.

The Bureau of Hearings and Appeals of the Social Security Administration which is responsible for the compilation process has estimated the average amount of time required for each step following the institution of suit. On the average, it takes 6.5 days for the U.S. Attorney to be served after a complaint is filed and 13 days for the Bureau of Hearings and Appeals to be advised of suit after this service. Once the Bureau of Hearings and Appeals is advised of the suit, it is approximately 40 days before the completed transcript is forwarded to the Reprographic Unit. During these 40 days, hearing transcripts and claims files are requested, prepared and received; the entire record is compiled and reviewed; recommendations as to defending the case on the record or remanding are made to the Office of the General Counsel; the record is processed by the Court Records Section of the Bureau; and finally the transcript is released to the Reprographic Unit. This same process took an average of 36.6 days one year ago, but due to the increasing case load the processing time is lengthening.

The printing process also has caused some delay. At present, the Reprographics Unit has the capacity of making 2300 plates (pages) per day without overtime. However, the current caseload from the Bureau of Hearings and Appeals far exceeds 2300 pages per day, and a backlog has been created.

These delays can best be understood in light of the current Social Security litigation caseload being handled by our Department. As of August, 1975, there were approximately 109,840 cases scheduled for a hearing within the Bureau of Hearings and Appeals. The figures for the period of January through August of 1975 demonstrate the overwhelming volume of cases for which transcripts must be prepared. In total, 4,625 new cases were filed in the courts during that eight month period. These cases break down as follows: Disability Insurance—1,889, Black Lung—2,453, Retirement and Survivors Insurance—164, Health Insurance—63, Supplemental Security Income—56 (Approximately 50 percent of cases received in the Title XVI area are concurrent in nature in that they also involve Title II disability issures). Furthermore, the number of new disability cases continues to increase at a rate of nearly 25 percent each year. The number of Supplemental Security Income cases is also expected to increase drastically. This projection is based on the fact that as of August, 1975, there were over 34,500 Title XVI claimants awaiting a hearing or Appeals Council consideration. Of this number approximately 2,500 should result in court action.

As can be seen from the current caseload, the delays in the preparation of transcripts are primarily caused by sheer volume. However, after the transcripts are completed, time is still required for preparation of the answer itself. The transcripts are sent to the Office of the General Counsel where a recommended answer is drafted. This recommended answer is then mailed with the copies of the transcript to the United States Attorney where it is put in final form and filed with the court. Mailing time is of course also a factor which impacts on the need to request extensions of time to file answers in these cases.

The entire process is very time-consuming, particularly in cases where the records are lengthy. Accordingly, extensions must be requested for many of these cases. In the event that an extension would not be granted, the preferential treatment of a few cases would increase the delay in processing the remainder of the caseload. We are keenly aware of the desirability of processing these cases promptly, both to relieve congestion in the courts and to settle the rights of claimants. At present we are doing our best to meet this objective under the limitations imposed on us. All cooperation received in obtaining time extensions is greatly appreciated.

Sincerely yours,

RANDOLPH W. GAINES,
Chief of Litigation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.
From: Associate Commissioner for Operational Policy and Procedures.
Subject: Federal Title XVI Litigation—*Terry Finnegan* v. *Matthews* (U.S. Court of Appeals, Ninth Circuit, 641 F. 2d 1340, April 16, 1981)—Information.
To: Donald A. Conya, Assistant General Counsel.

ISSUE

This is in response to your request for my recommendation on whether we should seek an appeal to the Supreme Court in *Finnegan.* I believe that we should not petition for a writ of certiorari in this case, but, instead, should publish a ruling of nonacquiescence. The issue in *Finnegan* is whether the Social Security Administration (SSA), when attempting to remove a grandfathered Supplemental Security Income (SSI) disability recipient from the rolls, must show that there has been "a material improvement in his medical condition" or that there was "a clear and specific error" made by the State in its original determination of disability under the former State program.

BACKGROUND

The plaintiff, Terry Finnegan, who had been receiving State disability welfare payments since 1972, was grandfathered into the SSI program in 1974. Following a continuing disability investigation, he was informed that SSI payments would cease because he was no longer disabled under either the Federal SSI program or the Washington State disability program which was in effect prior to January 1, 1974 (the effective date of the SSI program). SSA's decision to terminate *Finnegan* was affirmed by the U.S. District Court for the Eastern District of Washington. On April 16, 1981, the U.S. Court of Appeals for the Ninth Circuit reversed the decision of the district court and thereby reversed SSA (see tab A). In reversing SSA, the Court of Appeals found that the termination of Finnegan's benefits was improper because there was "no material improvement in Finnegan's medical condition or clear and specific error in the prior State proceedings." On June 25, 1981, the Court of Appeals denied SSA's request for a rehearing in *Finnegan.*

Section 1614(a)(3)(E) of the Social Security Act if the "grandfather" clause which provides for the continued payment of SSI to a converted individual who "is permanently and totally disabled as defined under a State plan . . . so long as he is continuously disabled as so defined." Section 1614(a)(3)(E) also limits eligibility for conversion to those individuals whon in December 1973 were receiving aid for their total disability under a State plan approved under title XIV or XVI, as in effect for October 1972. Individuals eligible for conversion must also have received aid for at least one month prior to July 1973. These limitations to the grandfather clause were added as a "rollback" amendment to prevent States from transferring their welfare recipients onto the disability rolls in anticipation of Federal takeover.

DISCUSSION

SSA interprets section 1614(a)(3)(E) to mean that individuals who satisfy its criteria are grandfathered into the SSI program and are thereby protected from termination of SSI benefits so long as they continue to meet the Federal or the former State plan definition of disability. When a continuing disability investigation is conducted to determine whether a grandfathered SSI recipient is still disabled as defined by the State plan, State statutes and regulations are available and used by disability examiners and Administrative Law Judges (ALJs) in adjudicating cases.

In *Finnegan,* the Court of Appeals rejected SSA's interpretation. According to the Ninth Circuit:

"An ALJ's inquiry must . . . focus on whether a clear and specific error had been committed during the previous State determination of eligibility and on whether the recipient's medical condition has materially improved. Absent in finding of clear and specific error in the earlier determination a recipient must logically have been 'disabled under a State plan;' absent a finding of subsequent material medical improvement a recipient must logically still be disabled 'as so defined.' "

In essence, the *Finnegan* court's order means that ALJs should not rely on their own interpretations of the prior State plans, but rather that they should weigh the current evidence against the State's initial disability determination to decide whether there was "specific error" or whether the recipient's "medical condition has materially improved."

SSA would face problems in complying with the court's order because in many conversion cases the evidence with which convertees were initially allowed is either incomplete, unavailable, or no longer in existence. In the case of Finnegan, it would be possible to comply with the court's directive because the record contains a copy of the State's initial disability determination in 1972, as well as pertinent medical evidence for that period. In many conversion cases, however, complete documentation regarding the State's initial finding of disability is unavailable. It would be difficult in those cases to show either improvement or error.

While we strongly disagree with the court's rationale and would face major problems in implementing the court's order generally, there are significant weaknesses in the *Finnegan* case. Mistakes were made in the legal defense of this case before the Court of Appeals. It seems that the U.S. Attorney's office defended this case without the advice of the Department of Health and Human Services' legal counsel and misinformed the court about SSA's position with regard to grandfathered SSI recipients.

In addition, there has been no improvement in Finnegan's medical condition since the original State allowance and according to our review of the medical evidence in file, it is questionable whether Finnegan is in fact not disabled at this time. Since the facts indicate that the State determination was one of judgment, and since we *know* that Finnegan has not improved, we believe that the Supreme Court might not think it appropriate for SSA to substitute its judgment for that of the original adjudicator.

RECOMMENDATION

I recommend that certiorari to the Supreme Court not be sought in *Finnegan*. Although the court's order is based on a faulty understanding of the continuing disability process, the standards applied by SSA and the practical problems in complying with the more restrictive standard erected in *Finnegan*, we believe that the factual situation in *Finnegan* makes it inappropriate for review of these issues by the Supreme Court.

If the Solicitor General decides not to seek certiorari, we believe it is critical that SSA publish a ruling of nonacquiescence in order to limit the holding of the Ninth Circuit to Mr. Finnegan. With a nonacquiescence ruling, we can attempt to argue this issue again before the courts in a case in which the plaintiff is clearly not disabled, where the State disability determination is in fact not available and where the case can be prepared properly without the legal flaws found in *Finnegan*. The Office of Hearings and Appeals agrees with this course of action.

Sandy Crank.

Department of Health and Human Services,
February 23, 1982.

From: Associate Commissioner, Office of Hearings and Appeal.
Subject: Ruling of Non-Acquiescence-Continuance of Cessation of Grandfatheree's Disability—Information.
To: All RCALJs, All ALJICs, All ALJs.

On April 16, 1981 the United States Court of Appeals for the Ninth Circuit issued a decision holding that Supplemental Security Income (SSI) benefits based on disability to a claimant who had been converted from the State welfare rolls to the Federal SSI program in January 1974 (grandfatherees) could not be terminated unless SSA showed that there was either a material improvement in the claimant's medical condition or a clear and specific error in the prior State determination.

I want to draw your attention to Social Security Ruling SSR 82-10c in the January 1982 quarterly Rulings publication, indicating the Social Security Adminstration's non-acquiescence in the Court's decision. Under SSA policy, it is *not* necessary to show that there has been improvement in the claimant's condition or any error in the prior State determination for benefits to be ceased. It is SSA's position that a granfatheree's SSI benefits based on disability may be ceasd when the claimant's disability, as shown by the current medical or other evidence, does not meet the criteria of the appropriate State plan or the Federal criteria—i.e., the impairment is such that the claimant is able to engage in substantial gainful activity (20 CFR 416.994).

Although the ruling addresses only criteria for ceasing disability for a grandfatheree, you should be aware that the criteria for ceasing benefits based on disability also apply where the claimant is a title II or SSI non-grandfatheree beneficiary. This basic policy is reflected in SSR 81-6 (January 1981, p.27).

Social Security Ruling SSR 82-10c is binding on all components of SSA including administrative law judges and the Appeals Council (20 CFR 422.408). SSA's policy must be followed in cases involving the issue of cessation of disability, including cases involving claimants who reside within the jurisdiction of the United States Court of Appeals for the Ninth Circuit.

LOUIS B. HAYS.

Chairman PICKLE. Well, thank you, Ms. Sweeney. I cannot help but observe, as you have stated in your testimony, you felt that the SSA primary concern was speed. I would say that you must have some—you have talked with the speed of 150 words a minute.

Ms. SWEENEY. I apologize.

Chairman PICKLE. We appreciate it. We are glad to have you.

We will ask Mr. Jonathan Stein, representing Community Legal Services of Pennsylvania.

STATEMENT OF JONATHAN M. STEIN, CHIEF OF SPECIAL PROJECT, COMMUNITY LEGAL SERVICES, INC., PHILADELPHIA, PA., AND ON BEHALF OF PENNSYLVANIA ALLIANCE OF THE PHYSICALLY HANDICAPPED, AND DISABLED IN ACTION OF PENNSYLVANIA

Mr. STEIN. Yes, Mr. Chairman, I am here actually representing out clients, senior citizens of Greater Philadelphia, the Pennsylvania Alliance of the Physically Handicapped and Disabled in Action of Pennsylvania. We appreciate the opportunity of giving this testimony this morning.

As representatives of the disabled and elderly of Pennsylvania, our clients who would unfortunately suffer most under many of the provisions of 5700, we come here to ask you to reconsider and reject the main thrust of this legislation.

In sum, it is our view that this legislation, in effect, scapegoats the administrative law judges and the U.S. district court judges for SSA's historic failure to arrive at correct and well-substantiated disability decisions at the initial and reconsideration levels.

Like the messenger who brought the king unwelcome news of failures abroad, the ALJ's and the district court judges have signaled for years, for almost three decades, in fact, the failures of SSA to be fair and correct in its initial decisionmaking.

H.R. 5700's perhaps simplistic approach is like that of the king of old, to cut off the heads of the messengers instead of addressing the underlying structural and systemic problems of an unchanging and arbitrary Federal agency whose feelings will largely go ignored by this bill. H.R. 5700, by setting back the clock on administrative justice for claimants seeking merely their due under the law, ignores almost totally the ongoing national scandal of continuing disability investigations and initial disallowances which are currently denying disability benefits to tens of thousands of disabled people.

These systemic denials should be addressed and remedied by this subcommittee, but not by taking aim at the judicial officers who are putting some checks at least upon an agency gone wild in its efforts to reduce the numbers who are seeking disability benefits. The real problems that should be addressed are the arbitrary denials and cessations, and I know, Mr. Chairman, you have heard a lot about this and I need not go over all the statistics which essentially come down to the highest initial denial rates in the history of the system.

With cessation rates approaching 50 percent, something on the order of 45 percent or so—this is, though, not a phenomenon of this year—I think this year's actions have just illustrated the longstanding problems, and we really have had people in this agency to take advantage of the existing weaknesses in the system which have been turning out poor decisions, poor decisionmaking for years.

This committee, in fact, noted in its committee report, actuarial condition of disability insurance since 1978, the adjudicative climate so-called had suddenly changed in the 1975 to 1979 period with an increase in denials and cessations without any change in the law or any major changes in regulations.

Previous to this subcommittee's report there were reports going back to 1960, the 1960 Harrison subcommittee, the 1969 study of the Center of Public Policy Research, a 1971 special SSA internal study, the Boyd committee in SSA in 1975, and GAO reports in 1976 to 1979. You have essentially 20 years of academic and congressional reporting essentially focusing on the inadequacy of SSA and the State disability determination agencies to arrive at correct decisions because they failed to marshal adequate medical evidence for claimants who were, in fact, disabled.

In terms of the specifics of the bill, although we support a number of minor—I would say incremental changes such as continuing benefits until the reconsideration stage, provision for voc rehab services for medically terminated CDI's, waiver of over-payments for periods before notice is given and adjustment benefits for 4 months after the month of termination. These provisions nevertheless, although they are well intended, totally fail to address the magnitude of the injustices being heaped upon disabled people who are currently being terminated.

Much stronger measures are essential and we hope that the subcommittee will consider these after this hearing. We suggest a number of them in our testimony here. We suggest that the greatly accelerated CDI's in effect be repealed, and that we return to a system which already reviews cases to the tune of 150 perhaps to 200,000 cases that were already being reviewed every year. And if, in fact, there are accelerated reviews of claims continuing, why should there not be reviews of denials and disallowances?

We heard, I think, Commissioner Svahn perhaps quite candidly and maybe suprisingly yesterday say that he saw an imbalance with pre-effectuation reviews that only reviewed the allowances. What kind of a system of fairness do we have that only looks at the allowances and not the other side of the coin, the disallowances? And we ask that for every check that is made of an allowance, that this agency also look at the disallowances and report to Congress specifically as to what those findings show.

We ask further with regard to continuing disability investigations that SSA by statute, because I do not think they will do it by policy, re-establish the very logical and commonsense requirement that medical improvement be shown before benefits are terminated unless there is newly discovered evidence of the original disability determination that it was clearly erroneous.

This is a fairly commonsense idea that if you have been on disability and you have gone through the hoops—and it is really a lot of hoops that you go through to get disability—that at least SSA should come up with some finding from someone that you have improved. And there should be that finding before anyone has their continuing benefits denied.

There are a number of courts who in the absence of legislation and in fact in the absence of SSA bringing back the policy which they did have up until 1976, a number of courts have ordered or found that this is a fair and a commonsense requirement in dealing with the statutory intent of Congress.

The Schweiker opinion of the court in the eastern district of Pennsylvania is appended to the testimony and illustrates in the example of a man suffering almost continuous pain wearing neck and back braces daily, found disabled by social security, within 1 year later he suddenly, miraculously, is cured, found not disabled any more but with no showing of medical improvement. And a Federal judge in Philadelphia quite properly said that in the absence of a showing of medical improvement he should be continued on disability.

Further, as a final procedural safeguard we believe that benefits should be continued not until the reconsideration stage but until the hearing, the administrative law judge hearing. And mainly because the reconsideration stage, even with the marginal improvements which we agree are well intended, will always be a rubberstamp unless other fundamental changes are made.

The same people using the same procedures using their own unpublished guidelines will be making these recon decisions. If delays and costs are considered a problem, then we suggest abolish the reconsideration stage altogether. Just get rid of it and streamline the process. Have a decent initial decision where all the efforts are made to get a good case, and then have a hearing later and forget about this whole consideration process and delay.

And this is not a radical proposal. Fifty States currently in the welfare programs administered for millions of public assistance recipients have had this procedure, this due process protection of continuing benefits until a hearing in place for 10 years. There have not been reported abuses of this despite there being an absence of overpayment requirement if the welfare appeal is lost.

It is time the social security and SSI recipients have the same due process protections against arbitrary and erroneous terminations.

Finally, in terms of procedural changes, I think, Chairman Pickle, you have heard a good bit about the gross inadequacies in developing the medical record. Because we have absolutely no faith in social security altering that, we suggest that as a matter of amending the act you require SSA to obtain, not just request, complete and sufficient treating physician reports for all medical personnel treating the individual at the time of review before terminating or suspending benefits.

And I think no one disagrees that treating physician reports are the best quality medical evidence, someone who knows that person best, and there is no reason why this source should be ignored or why this committee should rely on SSA simply sending out a form letter to a treating physician requesting that information. That information should and must be obtained in fairness to every disability, disabled person.

With regard to the second stage of changes that this bill proposes in increasing the role of the reconsideration process, we oppose all efforts to change the reconsideration process when it is being done at the expense of subverting the next stages, particularly the ALJ hearing step, thus closing the record after recon to new or additional evidence being submitted later would deny aid to thousands of disabled people who are not assisted properly by those at the first two steps to secure needed evidence.

Decisions are made at these early stages without treating physician evidence. The State agency fails to get back to doctors to develop inadequate medical reports rendered. Treating physicians are never told what the medical standards or tests are to apply. And as an example, we have never seen a first or second stage decision ever recognizing the relevance of pain as a disabling condition.

And contrary to what, Mr. Chairman, you may have heard, there is no intention on lawyers--I am talking for legal services lawyers who get no fees out of representing claimants—to delay giving medical evidence in. If there is medical evidence it is submitted as early as possible, but I might add is submitted with a note of skepticism, knowing what a rubberstamp the reconsideration process is.

All these inadequacies that we have mentioned will be swept under the rug in closing the record. It is often only when a hearing is scheduled that an attorney initially enters the case, because we are largely dealing with uncounseled, poor and people with very low educations.

A representative's main contribution is to do the work inadequately performed by State disability examiners and local SSA officers; that is, to secure and develop sufficient medical evidence. Yet this role is totally subverted through the closing record provision.

Face-to-face hearings at the recon level may be a helpful step, but again, not at the cost of undercutting the fairness of the system now. Let us see first what the effects of face-to-face recon hearings are before practicing the radical surgery that would greatly be disruptive of the ability of disabled people to secure benefits.

In the next and major section of the bill dealing with the uniformity of decisionmaking, we think these sections contain the most destructive proposals put forward to deny justice to disabled applicants.

A motion review of ALJ allowance is simply a means to harass and discourage administrative judicial officers from undertaking their sworn duties to apply the law, including SSA's own rules. This is apparent in part only because allowances, and again not disallowances, are to be reviewed. And I can tell you that the arbitrary ALJ decisions denying benefits to claimants that need Federal judicial review.

Again, this is, we believe, a totally misguided undertaking which covers up the reasons why those ALJ's who do reverse the agency find it necessary to reverse denial decisions.

In terms of the POMS, I agree with what Ms. Sweeney has said. The real problem there is in terms of uniformity is that SSA has failed to conform its policies to Federal court decisions and has refused to take cases to the Supreme Court. If POMS are made mandatory policy, at least they should be subject to Federal Register publication so the public can comment upon them and substantive rules.

The social security court idea we think should be totally rejected. Inconsistent judicial precedents and backlogs are no reason to make this most radical change in the system. Our Federal court system, by requiring Federal administrative agencies to conform their decisions within a circuit to the rulings of the U.S. Circuit Court of Appeals there and by the role of the Supreme Court thereafter to reconcile conflicts among the circuits can adequately deal with that uniformity problem if and only if SSA utilizes those practices. And the Finnegan case in the Ninth Circuit is an example of how essentially SSA refuses to use the Supreme Court in its proper role.

In terms of backlogs we have a few suggestions there, and they include empowering HHS regional counsel to agree to remands in certain cases to avoid needless knee-jerk reflex actions which lawyers, and particularly Government lawyers, do in these cases of just always waiting and using up time and filing answers and opposing every case, when an honest opinion from a U.S. attorney or HHS counselor—they have given me these opinions for the 14 years I have been practicing—acknowledge that in many, many cases the cases are so weak that they should never be litigated. And any lawyer in private practice would agree to a remand and acknowledge the weakness in that case, instead of the court and the system where they have no discretion to consent to remands and they have to go through months and often years of litigation where they know the end result will be a remand anyway.

We further suggest in terms of backlogs that with U.S. magistrates now available with their powers expanded that U.S. magistrates have been and can increasingly decide many more disability cases.

And finally, we believe that the procedures for developing better medical evidence and assisting claimants at the lower levels is the best way of minimizing errors and not having as many appeals as we have.

In sum, a social security court would create a two class or second class system of justice for poor and disabled people. You or I with our problems with the Federal establishment can go and get a U.S. district court judge under article III of our Constitution, but poor people would be given, and disabled people would be shunted off to a separate court system under the thumb of the HHS Secretary and be denied what the founders of our Constitution in the 18th century intended was an independent branch of government through article III to protect people from abuses of the administrative branch.

The answer is to correct the services, not to forestall or subvert article III which our Constitution has established for us, and particularly for the poor and the less advantaged people in our country.

We object to the elimination of credit remands which we think is absolutely essential when SSA loses files, when SSA confuses one claimant for another, when they have hearing transcripts that are inaudible. I mean this is the reality of what happens when cases get appealed. And prohibiting remands is not an answer to that.

It will only require and probably force judges to order benefits awarded rather than engaging in the sensible approach of a remand.

Concerning the definition of pain, we think there is a need to have a definition of pain. We think that before you even have a definition you have to have an agency that right now should be forced to recognize that pain is relevant to disability.

As I said before, we have never seen one disability decision made at either of the first two stages that has ever recognized pain in the history of our work in the program.

And so that is a threshold problem. Can you force an agency to acknowledge reality, a reality they have ignored for almost 30 years? But with the particular definition you give, we read that by a leading doctor at Philadelphia where they do full-time work with victims of pain, and this doctor advised me that in the most pain cases she sees or treats they would not fit in under your definition because there is no "clinical or laboratory diagnostic techniques," which is the definition available to corroborate the intensity of the pain that someone is suffering.

She gives an example of someone with rheumatoid arthritis, even where there is a physical deformity, where the degree of pain cannot be explained by any existing clinical or laboratory diagnosis.

Our final comment relates to the work force changes. By requiring participation in the work force for 2 out of the last 6 years in addition to the present requirements, essentially 20 out of 40 quarters, H.R. 5700 we believe pursues an unnecessary punitive policy which will hurt those disabled whose condition has degenerated over time into total disability placing them outside the work force prior to the disabling condition becoming severe. Thus, there will understandably be a gap in many cases in the work history closest to the onset of the disability with more continuous work coming earlier in time.

The current 20 out of last quarter's test strikes a reasonable balance, and we believe should not be altered. The H.R. 5700 change here would punish people by denying them aid precisely because their disability has over time reduced their ability to work.

In conclusion, we simply ask the subcommittee to take a look at what is happening out there right now at the arbitrary denial and termination problem, and do its best to direct its energies to that problem. And bear in mind that the little justice that people get in the system currently comes through the ALJ's and Federal courts, and let us not undermine that system, we ask.

Thank you.

Chairman PICKLE. Thank you, Mr. Stein.

Now, Mr. Kemp, we will be pleased to hear testimony.

STATEMENT OF EVAN KEMP, DIRECTOR, DISABILITY RIGHTS CENTER, WASHINGTON, D.C., ACCOMPANIED BY JANE KEMP

Mr. **Kemp**. Chairman Pickle, Mr. Shannon, my name is Evan Kemp. I am director of the Disability Rights Center in Washington, D.C., which was founded in 1976 with the assistance of Ralph Nader to advocate for the rights of physically and mentally disabled people.

I will testify today on one family's experience with the reexamination procedures for people on the Social Security Administration's disability rolls.

My wife Jane is with me today. In November 1973 Jane had part of a large tumor removed from her brain. The whole tumor could not be cut out because it was too near the vital midline center of her brain. In January and February 1974 the tumor that remained was treated with radiation. Following the operation and radiation Jane courageously attempted to return to her job as a schoolteacher, but she could not manage teaching either intellectually or physically. In October 1974 she retired on social security disability payments.

In June 1981 Jane's 1974 disability determination was reexamined by the Social Security Administration. Jane was given an EEG by one doctor and an IQ test by another. The EEG was normal, and on the basis of this one test a Government doctor determined that there was no tumor activity and Jane could go back to work.

Jane has had many EEG's both before and after her operation, and the EEG's have all been normal. Any competent doctor will tell you that a normal EEG does not rule out an active brain tumor. Conversely, an abnormal EEG does not mean you have a brain tumor.

The other doctor found that Jane's IQ was 72, and on the basis of this one test the doctor determined that my wife was not disabled and could go back to work.

This patent misuse of Jane's IQ score is a classic illustration of why many thoughtful people in our society question the value or propriety of IQ tests. IQ tests alone are never predictive of how well a person will perform in the workplace. People with IQ's of 37 can be gainfully employed and can live independently in the community. People with four times an IQ of 37 might be permanently disabled and unemployable.

In my wife's case her IQ dropped over 50 percent in a rather short period of time. It is absolutely shocking that a Government doctor with Jane's complete medical record before him would not order further tests to determine if the 50-percent IQ decline might be symptomatic of a serious medical condition.

How much a person weighs is not predictive of how well he or she will perform as President of the United States. If President Reagan without going on a diet lost 50 percent of his body weight in a very short period of time, I hope his Government doctor would show more commonsense than the Government doctor who reevaluated Jane's disability. A politician could lose over 50 percent of his muscle power in a short time and still be a statesman, but his doctor would be inviting a malpractice suit if he did not order tests to determine if there was a medical reason for the 50-percent decline in strength.

In going public today Jane is exhibiting some of the courage and concern for others that she has taught me in the last 9 years. The only reason that my wife has agreed to go public with a very private and personal matter is that she believes her case seems part of a disturbing pattern.

The evidence in her file has not been disputed. The tumor can be easily seen in a simple X-ray. All of her CAT scans clearly show hypervascularity, a characteristic of the border zone of tumors where growth occurs. Other objective tests show that my wife is quite ill and certainly totally and permanently disabled. There is nothing subjective about my wife's case where doctors of good will can differ.

Neither my wife nor I believe that her case is an isolated bureaucractic snafu that can occasionally occur both within and outside Government.

Jack Anderson has written about similar cases in his syndicated column. As the director of the Disability Rights Center I have been told of similar cases from around the country.

My wife's case illustrates that the Social Security Administration has become too zealous in culling the disability roles. If SSA can make such a clearly erroneous decision in such a simple case, what about the usual but more complicated cases where competent doctors can disagree? What about your constituents who live alone or who do not have a lawyer as a spouse? What chance do your constituents have who have not been seen or been under the care of some of the most renowned doctors in the country?

We are going public today because we believe that Jane's case illustrates a pattern of gross misconduct, maybe even human rights violations, that if allowed to continue will bring disgrace on both the executive and legislative branches of our Government.

Jane and I hope that this committee will hold hearings at the earliest possible time to right a great wrong that is being done to many in our society who are least able to defend themselves.

Thank you for the opportunity to present our views. I would be pleased to respond to any questions you may have.

[An attachment to the statement follows:]

[Social Security Notice of Reconsideration]

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
SOCIAL SECURITY ADMINISTRATION,
February 8, 1982.

Claim Number: 245-54-2376.

JANE C. KEMP,
Washington, D.C.

In view of your request for reconsideration, all the evidence about your claim has been carefully evaluated. It has been determined that the previous decision was proper under the law.

A period of disability was established for you beginning October 1974. The law provides that an individual's disability period shall end if the person is able to do his or her usual occupation or any other kind of substantial gainful work considering the person's age, education and work experience. The law also provides that an individual will receive benefit payments for the month disability ends and the following two months. The evidence in your case shows that you became able to do substantial gainful work in June 1981. Therefore, it has been determined that entitlement to disability benefits ended with the month of August 1981.

On reconsideration, all the evidence was reviewed, and no condition was disclosed that would prevent you from working.

If you believe that the reconsideration determination is not correct, you may request a hearing before an administrative law judge of the Office of Hearings and Appeals. If you want a hearing, you must request it not later than 60 days from the date you receive this notice. You may make your request through any social security office. Read the enclosed leaflet for a full explanation of your right to appeal.

EXPLANATION OF DETERMINATION

Name: Jane C. Kemp.
SSN: 245-54-2376.

We have just completed another careful review of your claim. The following reports were considered in deciding your initial claim. We did not obtain any other reports because the ones shown below had enough information to re-evaluate your condition.

1. G. F. Molinari, M.D., Report of August 11, 1981. 2. Jacob Katzow, M.D., Report of August 11, 1981 and May 18, 1981. 3. Elliot Wilner, M.D., Consultative Examination, Report of July 9, 1981. 4. Donald Fisherman, M.D., Consultative Examiniation, Report of June 29, 1981. 5. Stephen Chiknas, Ph. D., Consultative Examination, report of June 29, 1981. 6. Louis Decker, Ph. D., Consultative Examination, Report of June 24, 1981.

You said that you are still disabled due to a brain tumor.

The medical evidence shows that your brain tumor has responded to medical treatment and you have been relatively seizure free for the past seven years. You are able to communicate with others and perform the activities of daily living. Therefore, disability benefits were properly ceased effective June 1981.

Based on your description of the job as a teacher you performed for the past 13 years, we have concluded that you cannot return to that job; however, you can perform work that is unskilled and non-stressful.

[Social Security Termination Notice]

OFFICE OF DISABILITY OPERATION,
Baltimore, Md., September 4, 1981.

Claim Number: 245-54-2376 HA.

JANE C. KEMP,
Washington, D.C.

The law provides that an individual's disability period shall end if the person is able to do substantial gainful work. The law also provides that an individual will receive benefit payments for the month disability ends and the following two months. The medical evidence in your case shows that you became able to do substantial gainful work in June 1981. Accordingly, the last disability benefit payment to which you are entitled is for the month of Aug. 1981. This determination is based on all the evidence in your file, including any additional evidence you may have submitted. The decision on your claim was made by the Social Security Administration on the basis of a disability determination by an agency of the State in which you live. Physicians and other trained disability evaluation personnel in the State agency participated in making this determination.

Since you are no longer entitled to benefits, your hospital and medical insurance coverage under medicare ends the last day of Oct. 1981. Please destroy your health insurance card after the last day of coverage indicated above.

You will be notified at a later date if an underpayment or overpayment of benefits exists on your claim.

If you have any questions about your claim, you may get in touch with any social security office. Most questions can be handled by telephone or mail. If you visit an office, however, please take this notice with you.

THE GEORGE WASHINGTON UNIVERSITY MEDICAL CENTER,
DEPARTMENT OF NEUROLOGY,
Washington, D.C., August 11, 1981.

MS. GLORIA JONES,
District of Columbia, Department of Human Resources, Social and Rehabilitative Administration, Disability Determinations, Washington, D.C.

DEAR MS. JONES: this is regarding Ms. Jane Kemp. Thank you for the opportunity to discuss this case with you this afternoon by phone.

Since I understand from that phone conversation that it is the intention of the Department to discontinue the disability for Ms. Kemp, I must formally appeal that decision. I have been following Ms. Kemp for almost five full years. She still has an oligodendroglioma of the right hemisphere of her brain. That tumor is growing. I understand that you have made a recent determination of an IQ of 72. This woman was a school teacher; this is a progressive deterioration of IQ. Secondly, the physicians who saw her suggested no sign of tumor activity—this cannot be done in a single sitting. Less than one year ago, Ms. Kemp sat on the grand jury of the District of Columbia. I doubt that an IQ of 72 would permit that and therefore I submit that this is further indication of the rapid deterioration of her mental processes.

The reason that there is such a paucity of physical findings such as paralysis and sensory loss on the left side of her body due to this brain tumor is that the original surgery followed by radiation left plenty of room for the tumor to grow. All of our CT scans show hypervascularity, a characteristic of the border zone of tumors where growth occurs. The original tumor was so close to the midline center of the brain that at the time, Dr. Goy Giotum of Duke University knew that he left a tumor behind. During the surgery he deemed it necessary to do subtotal resection of the tumor because of the proximity to the vital midline centers of the brain having to do with memory, and even some feeding behavior and some emotional activity.

The inevitable course of six or seven years proved him right. Nonetheless, every CT scan that we have obtained over the past four and a half years shows continued tumor activity. I'm sure that the doctors who evaluated her case acted in good faith but it is impossible to tell at a single sitting in a one-time evaluation where a given patient is along a course of an illness that spans years. I am absolutely convinced that her tumor is progressive and that she is deteriorating rapidly, particularly in the last 22 months. That deterioration includes particularly memory function, which I am sure has been evidenced in the recent IQ tests, and emotional behavior.

Ms. Jane Kemp is, in fact, totally disabled and will remain so for the rest of her life.

Yours Truly,

G. F. MOLINARI, M.D.,
Professor and Chairman,
Department of Neurology, George Washington University.

AUGUST 11, 1981.

MS. GLORIA JONES,
D.C. Department of Human Services, Bureau of Rehabilitation Services, Disability Determination Division, Washington, D.C.

DEAR MS. JONES: Jane Kemp has asked me to write to you regarding her Social Security disability payments. She is appealing your decision to discontinue payments.

Jane Kemp has been under the psychological care of Dr. Mimi J. Speilberg, Ph.D., and myself since February 17, 1981. Dr. Spielberg has seen her for psychotherapy for her depression on a twice-weekly basis, and I have followed her medication needs and consulted on her therapy.

Mrs. Kemp has had a series of psychological tests these past years which have revealed progressive deterioration. Following her brain tumor operation, she attempted to go back to work and could not manage intellectually or physically. She requires long periods of rest every day. Some of the fatigue has been due to depression and is being relieved, to an extent, by psychotherapy and medication. She will never have the energy to join the work force in any capacity. The main goal of therapy and medication is to help Jane Kemp stay at home and out of the hospital as long as possible.

If you have any further questions, please call me.

Sincerely,

JACOB J. KATZOW, M.D.

D.C. Department of Human Services,
Bureau of Rehabilitation Services,
Disability Determination Division,
Washington, D.C., July 29, 1981.

Ms. Jane Kemp,
Washington, D.C.

Dear Ms. Kemp: Earlier we told you we were assisting the Social Security Administration in determining whether you remain eligible to receive monthly benefits on account of disability. To be eligible for such benefits you must be unable to engage in any substantial gainful activity by reason of your impairment.

On behalf of the Social Security Administration, this is to notify you that based on evidence now in file it appears that a determination would have to be made that you regained ability to engage in substantial gainful activity in June 1981. Current medical evidence in file indicates that your condition has greatly improved. You should now be able to engage in medium work.

We are writing at this time to give you the opportunity, if you feel that you are still unable to work by reason of your impairment, to present an additional statement or evidence you want to be considered before a determination is made. If you want to submit such a statement or evidence, please send it to us within the next 10 days using the enclosed envelope which requires no postage.

If you do not write us within 10 days we will forward your records to the Social Security Administration where formal determination will be made as to your continuing entitlement to benefits. It is important, therefore, that you let us know within 10 days if you want to submit a statement or evidence even though you may need more time to submit it.

When a formal determination is made, you will be notified in writing by the Social Security Administration what the determination is. If it is determined that you have regained ability to engage in substantial gainful activity and therefore that your disability ceased, June, 1981, you will be eligible to receive benefits for the month in which disability ceased and for each of the two months following that month. Accordingly, the last benefit check to which you would be entitled is for the month of August, 1981.

ADDENDUM

If you are participating in an approved State Vocational Rehabilitation program, you may be eligible for continued payments beyond the time designated above. The Social Security Adminstration will also notify you if you qualify for continuing benefit payments.

Sincerely yours,

Ms. Gloria Jones,
Claims Examiner.

Chairman **Pickle**. Thank you, Mr. Kemp, and I thank all the panelists—let me state first, Mr. Kemp, thank you for your recitation of your wife's case. We are sympathetic with what has happened.

Mr. **Kemp**. I just wanted to——

Chairman **Pickle**. I must say that the question about the doctors' findings, whether they did a good or poor job or thorough job, is of no question perhaps, but the social security people must look at the medical evidence. A real problem: One, how do we handle these kind of findings; what procedures do they follow; and we do not like to hear these kind of things, these cases. But I am glad that you did come and go public on it.

We are trying to, by this legislation, help to correct some of these happenings. I am a bit concerned at the panel. You seem to think that the State agencies have been concerned only with speed, an emphasis on speed. Particularly, Ms. Sweeney, you seem to think that that is what they are interested in and that is the sole thing they are interested in.

Ms. **Sweeney**. It is not just the State agency, Mr. Pickle. The reason they are interested in speed is because SSA is requiring them to deal with incredible numbers of cases. Mr. Brown testified before you. The Tennessee DDS person testified before you in the volume provider hearings that he had boxes full of cases that he had to decide quickly that he had not even gotten to. That is a very common problem.

Chairman **Pickle**. Well, the regulations under the State agencies cannot be terminated just on partial information. They can be terminated if it is the quality of decisionmaking. Below that level speed and speed alone is not the primary consideration, although I must say they have some 300,000 cases thrust into these offices across the land. Speed does have to become a factor. I am hoping that a lot of problems we have are a result of this accelerated review rather than the basic procedure.

But to all of you I want to say that we think first that there have not been too many of these cases brought in, and too many of them have been automatically—at least a high percentage have been ruled as being able to go to work. And we question that finding just on the volumes alone and to some extent on the speed in which it has been developed. We also question, I do, the procedure or the criteria that the local offices must follow in making these findings. I think we have to examine that.

But I am concerned that most of you seem to think that you want to keep the status quo. You must think that the changes we are recommending are not good, that you want to keep what we have by and large.

Now, we have a tremendous backlog of cases, and let us start first with the reconsideration level. You have all spoken against that, most of you have. And could we not agree that either reconsideration ought to be made a workable, viable level of review or else it should be done away with?

Ms. **Sweeney**. I would certainly agree with that.

Chairman **Pickle**. If we just do away with it entirely, then you go from the local level immediately up to the ALJ level almost.

Now, they have a tremendous backlog now. They cannot say grace over what they have, and they contend they cannot get more hearing examiners and ALJ's, and even if they could find them, I do not know whether OMB would approve it. We get locked into this GS-12 and GS-14 upgrading of staff attorneys.

If we do not have a way to process many of these cases, then you are going to have tens of thousands of cases just going right up to the ALJ level, and I do not see how they can ever come up for air.

We are trying to say is there a proper way to pull this hearing process back so that we could make reconsideration a meaningful process?

Mr. **Stein**. Those cases are already going up to the ALJ stage. To justify this, the ALJ process, it is somehow a dam that stops the flood. It is not stopping the flood right now. The rejection rate is over 80 percent, 80 to 90 percent. It corrects some errors, and the question is whether the correction of 10 percent of the cases is a sufficient justification for the expense, the delay of having that second stage but—go ahead.

Mr. **Coven**. If I could just make a couple of comments, Mr. Chairman.

I think we almost start out with a false assumption. The way to cut down on the number of cases going to the ALJ is to make the agency do its job in the first instance. The problem that we are seeing is that they are simply pushing out cases because—well, for a whole bunch of reasons but mainly because——

Chairman **Pickle**. Maybe——

Mr. **Coven**. The other part of that, I think in a very practical way, is that the more hoops you make people jump through, you are right, you are going to lose—there will not be as many cases going up to the ALJ, but it is because people get so darned frustrated by this system and get these constant papers. People come to me and they say I cannot work. I got out of a mental institution 2 months ago. I am in a rest home and I am getting told that I am not disabled. There is no way I can work, but I cannot go through reconsideration. I cannot go to an ALJ. So you will lose people. I mean the system operates in cutting down the numbers of people going to ALJ's by cutting out what are essentially valid claims.

Chairman **Pickle**. But would we have less appeals if we had more evidence submitted at an earlier stage? Would that be workable? Would it be fair? They would have a chance to submit more evidence.

Mr. **Kemp**. I have a problem with reconsideration proceedings. Basically again it is personal. No. 1, we were never told that we had the 5 days' mailing time or the 10-day grace period. It was all to be done in 10 days.

The other thing is that especially with people that might have some mental problems, that the termination letter should be registered. It bothers me very much, that it is just a plain old SSA envelope.

Chairman **Pickle**. The bill widens out your hearing time, the mailing time, and notice time greatly. We are trying to cure that part of it with the legislation.

Mr. **Kemp**. I saw that.

Chairman **Pickle**. Do you not approve of that?

Mr. **Kemp**. No. 1, I do think that all notices of termination should be by registered mail.

Chairman **Pickle**. Would you appeal—given more time to appeal, keep the benefits going until——

Mr. **Kemp**. I think that the key period——

Chairman **Pickle**. I am trying to get you to say yes. I would like to think that the panel would think there is something in the bill to agree with.

What you want to do is protect the lawyers more than you do the clients.

Ms. **Sweeney**. Please. That is not the case.

Chairman **Pickle**. I do not charge that, but when we are trying to change a system and make it better——

Ms. **Sweeney**. We think that is very important. We think that is very important, sir.

I would like to clarify something you said. We are not here to protect the status quo. We are not here to defend the Social Security Administration. We think you have a structure that can be made to work. We do not think that it works now. We do not think that any effort is being made by the Social Security Administration to assure that there is proper evidence development.

We think it is more appropriate for this committee to be saying to the Social Security Administration why do you not try and make the current system work before we go and make all of these very expensive changes, because that has not been done. They do not do that. There is no medical evidence in the files. And I think it would be more appropriate for ALJ's to be telling you that, but certainly the staff attorney today told you exactly that.

Chairman PICKLE. We are trying to do that. We are trying to get more medical evidence on the record at an earlier stage, and that is the purpose of the hearing.

I have the feeling you think automatically the State agency's level of approval is very slow and the ALJ is just good.

Ms. SWEENEY. We would not deny that there are problems with the ALJ's either.

Chairman PICKLE. What about the State level of approval or affirmation on these cases?

Mr. ARNER. We do have in the law—Social Security says there is a 95-percent accuracy rate I think on the initial level, something like a 97-percent accuracy rate on the reconsideration. I have not said it tells me anything. I am just telling you there is a quality assurance system at the State level, and we are given statistics.

For instance, I have noticed one thing in recent months. I think Mr. Kemp's was the D.C. agency, correct?

Mr. KEMP. Yes, sir.

Mr. ARNER. It has one of the lowest quality assurances of the whole country. We have a provision in the State-Federal regulations if they fall below a threshold on quality assurance that agency can be terminated. I think they are very close to the threshold. They are one of the few agencies that are way down at the bottom. They could probably be fairly close to termination under the provisions of the existing regulations.

This is not perfect, but that is what we were saying. It is not just processing time. The reason for termination is where they fall below the threshold on quality.

Now, I am not saying the quality assurance program is perfect. We have investigated it, looked at it in the past. However, there has not been a quality assurance of the ALJ's for the last 5 years. This is a part of the own-motion review process. They are beginning to look at ALJ allowances because they had not looked at them in the past. So this is what we are looking at.

Ms. SWEENEY. Well, I guess we are very concerned that there be a review of ALJ denials as well. But the bigger problem is if you look at the regulations that Social Security issued on the Federal-State relationship, there is nothing in there that indicates how they go about doing that quality review.

Mr. ARNER. No.

Ms. SWEENEY. All they say is you have to have enough evidence to justify your decision. It is much easier to have very little evidence to justify denial than it is to have sufficient evidence, so its accuracy rates are just totally off.

Mr. **Arner**. They tie in directly to the SPAR quality assurance system. I do not know if you have looked at it or not and you disagree with it, but they looked at just those questions—is the case adequately documented—and you will get a statistic on that. So they do look at that in this review.

Mr. **Stein**. Mr. Pickle, I think our problem—I think we agree with you. What is needed is to get better medical evidence, better quality and more sufficient evidence at the early stages. I do not think, though, that the way you do that is to close the record, because that the thrust of that is to say we are going to supposedly create, put a gun at the heads of every recipient who in theory has a choice. Do you give this evidence now, do you wait until later?

Now, I think if I might suggest that that might be aimed at a small minority of cases where you may have some evidence that some lawyers—and they are not legal services lawyers because there is no financial incentive legal services have here. Some lawyers may—and I guess that is cynicism—withhold some evidence. It is not, though, a phenomenon that explains the majority of cases where there is insufficient medical evidence in the record.

What we should be all insisting upon is that SSA do the job and not rely on outside advocates to do their job for them of having adequate medical evidence in the record through such means as requiring treating physician evidence, which is not a requirement now. And we think that is the direction that one should go in and not through a means of closing the record.

Chairman **Pickle**. I will recognize you in just a minute. Let me ask Mr. Shannon if he would like to make any inquiries of the panel.

Mr. **Shannon**. Yes. Thank you, Mr. Chairman.

One of the things that strikes me about this colloquy that has been going on is the fact that the assumption has been made that people have adequate representation up through this reconsideration process when it has been my experience that oftentimes people do not.

Now, all of you speak to cases where you have represented people, and that is fine. That is what you are here for. But how many people do not get representation? I have represented people in this situation when I was practicing law as a private attorney, and I never got a buck out of one of these cases. I certainly never got any money up front. And without legal services being available to a lot of people I would imagine we are going to see a lot more people going through this process on their own without representation.

How many people get representation up through the reconsideration process?

Mr. **Stein**. There is practically no one. We represent practically no one at those first two stages, in fact, because we cannot. There are hardly enough of us. We can hardly represent people at the ALJ stages.

Mr. **Shannon**. You do not even represent people at that stage.

Mr. **Stein**. We do not. We get people only when they have either requested a hearing or have a hearing scheduled 2 weeks from now, so closing the record essentially penalizes the counsel of the majority of claimants who are making appeals.

Mr. SHANNON. H.R. 5700 would say we have to have representation to make your case at a stage where nobody has it now or very few people have it now. Is that correct?

Mr. STEIN. Right. It would make every claimant counsel mandate a right to representation at the initial stage. Then in some theoretical sense it might have some appeal but not the current situation.

Mr. SHANNON. Mr. Coven.

Mr. COVEN. Yes. I would—and I think this might be important from my philosophical perspective—it begins to be described almost as an adversarial process, that the State agency is attempting to keep people off the disability rolls, and that you need to have representation to provide evidence to get social security to finally agree that these people are in fact disabled.

There should not be an adversarial process. What the posture of Social Security ought to be is to do a very thoughtful and responsible job of determining, based on all the evidence, if a person is disabled or not.

Chairman PICKLE. We do not disagree with that.

Mr. COVEN. That by changing it to—by cutting off evidence at the reconsideration level, by putting the adversarial hearing at the reconsideration level, you are in fact transforming what I think is already truth in fact in many situations, and that is making the State agency look to deny benefits rather than to thoroughly investigate the claim.

And also, Mr. Chairman, I just want to respond to your earlier claim. Certainly none of us on this panel, I think any of the four of us, are particularly interested in the status quo because we represented far too many people who have been hurt by the system.

Mr. SHANNON. It was my impression—not to interrupt you, Mr. Coven—that the point that was made was that H.R. 5700 is worse than the status quo and not that the status quo is acceptable to you, is that correct?

Mr. COVEN. I think there are certain portions of H.R. 5700 that we support, and I want to be clear about that. But there are other things that I think would adversely affect disability claimants. And what I was going to say is that I hope, Mr. Chairman, that you and the committee staff will take a look at the report that we wrote on the Massachusetts Disability Determination Service, because we list literally a number of dozen recommendations, changes that could be made in the Disability Determination Service that we think gives a reasonable balance of protecting the disability claimant as well as the fiscal integrity of the system.

Mr. SHANNON. Mr. Coven, I want to discuss the Massachusetts system a little bit. You list in your testimony a number of areas where the Massachusetts agency has failed to protect people's rights. Specifically, looking from a Federal perspective, is the problem just a lack of resources at the State level to administer the program?

Mr. COVEN. I think that is a significant problem. No. 1, it has been said by experts in the field that I think a certain caseload of something like 70 cases is an appropriate caseload for a disability examiner. It is well over 100 in just normal disability applications per examiner in the Boston region. With the CDI's coming on, the caseload volume is simply enormous.

There is an attempt to push out cases, and I am not saying it is malicious; but what happens at least in the examiners I have spoken to is that they write to the treating physician, the treating physician does not respond within 7 days, and they simply deny the claim rather than paying it or trying to follow up on it. The same is true of CDI's now. They send the letter out saying you have 10 days within which to submit additional evidence. If a person does not understand that, if they are having trouble getting a letter from the doctor, if they are having trouble getting their medical records——

Mr. SHANNON. I am trying to work through this bureaucratic labyrinth. I am trying to figure out why it is that we are seeing these uniform negative results across the country. Obviously there are some policy decisions which have been made here in Washington that are affecting the way this program is administered across the country.

Is it merely the volume of cases? Are there quotas—to put it very simply— which are being passed down, in your opinion, or is it——

Mr. COVEN. I have tried to investigate because that is something that certainly occurred to us, and we have been unable to find that there are quotas delineated on how many cases ought to be terminated. But there is certainly pressure to get these cases decided and out. And in most cases those sorts of time pressures mean denying claims or terminating. There are, you know, let us not be naive about the signals that are being sent by Washington either. I mean people—a disability examiner knows that quality assurance that Mr. Arnett talked about reviews only paid decisions, they do not review decisions that have been denied.

When their decisions are reviewed, they know in terms of advancement positions within the agency, promotional jobs are dependent on the type of reviews they get.

Mr. SHANNON. The only way they can really protect themselves from being reversed is by denying. Is that the way the system works?

Mr. COVEN. That is right. That is exactly right.

Mr. SHANNON. And so you think that there is a lot of bureaucratic bias toward denial.

Mr. COVEN. There is tremendous pressure emanating from Washington just when you hear the Social Security Commissioner saying, as a matter of fact, definitive fact that something like 38 to 50 percent of people who the State agencies are finding to be disabled are not in fact disabled.

What does that say to a rank and file disability examiner whose ultimate boss is telling him they made a mistake in 50 percent of their cases? That is tremendous pressure emanating from the Reagan administration to start reviewing, becoming tougher, tc apply a more stringent standard than this Congress has set out in its statute, to deny cases rather than trying to thoroughly investigate claims.

I mean what I am trying to say is what it is like to be a disability examiner, but more important, what it is like for these claimants who are either being terminated or being initially denied. It is an enormous problem.

Mr. SHANNON. Mr. Kemp, your testimony was very striking. You submitted a letter from a doctor, I guess, which was Dr. Molinari.

Mr. KEMP. Yes, sir.

Mr. SHANNON. And he wrote,

> I am absolutely convinced that your wife's tumor is progressive, and she is deteriorating rapidly, particularly in the last 22 months. Deterioration includes particularly memory function, which I am sure has been evidenced in the recent IQ test and emotional behavior. Mrs. Jane Kemp is in fact totally disabled and will remain so for the rest of her life.

What was the response from Social Security to this letter?

Mr. KEMP. They denied the reconsideration.

Mr. SHANNON. After receiving that letter it was just a flat denial?

Mr. KEMP. Yes. I think you have the denial letter, too. It is dated February 8, 1982.

Mr. SHANNON. Yes. That is just hard to believe except that we have been getting so many of these cases that this is not an isolated case by any stretch of the imagination. Every one of us in our districts have been getting hundreds of cases like this coming into our offices.

Mr. KEMP. Yes. And that is why I went public. The Disability Rights Center does not handle cases but we get calls. In the last 6 months there has been a tremendous surge of these calls. And though I do not have any material in front of me—they are just phone calls—they do seem like my wife's. Jack Anderson has written about it. You brought up the point about attorneys and when they get in the process. I do not think you would find an attorney entering the process at reconsideration because it is not necessary. I think people have faith that the Government is trying to do good and trying to do right.

I never considered getting an attorney until after I got the February 8 notice, because I was sure that on reconsideration it would be corrected.

Mr. SHANNON. And so to close the process at that point would essentially deny those people the right to adequately and effectively make a case.

Mr. KEMP. Sure.

Mr. SHANNON. That is what it seems to me. I can remember handling a case where the doctor had screwed up in writing the report. He just did not know how to write the report, what to say. He was having health problems of his own at that time, and I got involved after the reconsideration process. And if the process had been closed at that point, that person would not have had any ability to make that case.

Mr. KEMP. That is true.

Mr. SHANNON. I just have to believe that is a common case.

Let us approach it from a different perspective. What are the provisions of H.R. 5700 that will improve the system?

Mr. KEMP. I would like to make one comment. I do not want to appear terribly negative, but vocational rehabilitation for disabled beneficiaries probably will not be cost effective. Usually I am very much in favor of vocational rehabilitation, and it almost always is cost effective. But I do not think in this particular situation it would be cost effective.

No. 1, we have about 9 percent unemployment in this country. No. 2, these people would have a gap in their work record. And if an employer inquired about this gap and found out that they were on social security disability payments, I think he would be afraid to hire.

I think the second biggest reason why employers do not hire disabled people is because of fear of higher employee medical costs. I am almost always in favor of vocational rehabilitation, but in this one narrow area I do not think it would be cost effective.

Ms. SWEENEY. May I just add that we are—we think the provisions on the volume providers are a very good step. The problems we have heard at the hearings about the low fees that States pay seems to be a very big obstacle to getting competent physicians to take the cases. I think that is very important.

I share some of the concerns about the carrier, because I am not sure that they would not create delays that would result in discouraging physicians from taking part in the process. The provision in the bill that would waive overpayments that result because a person's cessation date is based upon the consultative physician's examination 3 or 4 months before the notice, we think is critical. We have been getting calls where States are uniformly doing exactly that. They are sending somebody in for a consultative physician examination in August, and because of delays in their own system, 4 or 5 months later the person gets a notice saying that not only are you not disabled, but you owe us 4 months of benefits. I think that creates an additional obstacle and impediment to somebody deciding that they want to appeal and something they should not have to take into account at that point.

The provisions, as I indicated before, Mr. Pickle, in your bill that would assist people who are not disabled in going back to work through the CDI process I think are very important. Our problem is that there are a lot of people who are not going to be able to work and who will not be able to benefit from those provisions.

Mr. STEIN. I would like to add to what Eileen said, Mr. Shannon, Mr. Pickle.

The provision allowing benefits to continue until reconsideration I think is a good, although incremental, small step in the right direction. I think we have some problems in subjecting that payment to overpayment if the appeal is lost. I think that could be ameliorated if there was good cause or reasonable basis to take that appeal. There should be some proviso that it should not in every single case be subject to an overpayment.

The providing face-to-face evidentiary hearing at the recon stage is again, I think, a very helpful step but not tying that to closing the record. Let us see what face-to-face hearings do. You know, it might well lead to a better process. It might cut down on those appeals to the ALJ stage. And let us see what happens before we take the more radical step of closing the record.

The indexing of child work—and I think it is overdue and——

Mr. SHANNON. Well, you have some things to work there with, so we have some things to work on there and perhaps build on when we go to markup.

Thank you, Mr. Chairman.

Chairman **Pickle**. We would be pleased to receive any other information you have, any other suggestions. The purpose of our legislation is to try first to slow down some accelerated reviews, because we are hearing some horrible stories, accusing the SSA of going full-speed ahead just to balance the budget; that we ought to slow the process down some. So I would agree with you that speed is not a factor we can ignore, but neither do we want to slow the process down indeterminably.

In some States, some areas of the country the processing time on these court cases are indeterminably slow. In West Virginia in one portion of the State the delay time on these cases goes 12 months or more, and in the southern part of the same State—I believe it is West Virginia—the delay time is some—it takes 54 months for a case to be disposed of.

When we had that report we could not believe it, when a lady called in and said she could not wait that long, it would take 54 months to get a case decided. And we could not believe it, and the staff checked, and it was true.

Now, somewhere in between, given all the time in the world and getting some kind of speed at the level we have to ask for, I do not think the delay is attributed just to the lower level. It goes to the higher court level, too. And somehow we have got to get a better balance on this, on the whole system, and that is the purpose of the legislation, to try to proceed better.

Mr. Arner, do you have any questions you want to ask any of the witnesses? I would be pleased to recognize you?

Mr. **Arner**. I would just say we have been looking at these problems for a long time. The problem of reconsideration, we have been looking at this since 1959, eliminating reconsideration then in the structure of the system, so these things have been thought about for a long time. And I guess there are no easy answers, but we continue to look at them.

Chairman **Pickle**. Mr. Shannon.

Mr. **Shannon**. Thank you, Mr. Chairman.

I just want to ask you whether or not you think that any of the problems in your experience, the problems that exist in the Commonwealth of Massachusetts with Massachusetts rehabilitation can be addressed at the State level, or must they be addressed by us here in Washington?

Mr. **Coven**. That is a difficult question, Congressman Shannon. I do not know if I could give you a good response. Certainly it is a State agency that has to follow some guidelines, but I think that essentially because all of its activities are under contract with the Social Security Administration, and allegedly they are following the directives or should be following the directives of the Federal agency that they are really problems that ought to be resolved in the first instance by this committee and Congress.

Mr. **Shannon**. You see, one of the problems I have, and this is one of the problems of federalism, I guess, is pinpointing responsibility and exactly how a decision made in Washington works its way through the Washington bureaucracy down to the State level, to the State bureaucracy, and is implemented with results we are seeing with the disability system today. You know, the State blames it on us, and some of us blame it on the State, and nobody can exactly find out where the decision was made.

I think it is obvious it was made for budgetary reasons, but there is a kind of bureaucratic quasi-quota being applied that is having uniform results across the country. We just pick that up from what we hear in our own districts.

But how we deal with it, whether we should take the State out of this completely I think is an issue that the Congress should be willing to confront.

Mr. COVEN. I think that is right, and I think Congress began to move that way last year, and in fact, the Federal agency began moving that way last year when it found that where the State agencies failed to meet certain performance quotas that there could be a Federal takeover of what has essentially been a State function.

Let me say that there is an institutional interest on the State to get their agencies to properly pay claims, because if not, a lot of these claimants end up on State-funded general relief programs where there is no Federal reimbursement whatsoever.

Mr. SHANNON. So it cuts both ways.

Mr. COVEN. That is right.

Mr. SHANNON. Well, I know that you all have some concerns about H.R. 5700 and many of the provisions involved in it. I just want to say that I am sure I speak for the chairman and the members of the committee in saying that we want to work with you as we work on the piece of legislation, and see whether we can turn that into a more positive piece of legislation before we get through. And so we will be calling on you for that purpose.

Thank you very much.

This hearing is adjourned.

[Whereupon, at 12:17 p.m., the hearing was adjourned.]

[The following was submitted for the record:]

STATEMENT OF GEORGE A. CONN, COMMISSIONER, REHABILITATION SERVICES ADMINISTRATION, OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES, DEPARTMENT OF EDUCATION

Mr. Chairman, I am glad to respond to your request for my comments regarding the rehabilitation provisions of H.R. 5700. Permit me to observe at the outset that the Administration has not yet taken a position regarding the Bill. While I am not able to comment on each of the rehabilitation provisions in section 17 of the Bill, I would like to point out for your consideration some concerns—first, on the Beneficiary Rehabilitation Program and, second, on the proposed two-year placement program.

I. BENEFICIARY REHABILITATION PROGRAM

The Omnibus Budget Reconciliation Act of 1981 restructured the Beneficiary Rehabilitation Program (BRP). Until the Department of Health and Human Services (HHS) and RSA working with HHS have more experience with the reformed BRP and evaluate the program and its operation, it would be inappropriate to change the statutory provision.

The BRP concerns I have in H.R. 5700 involve the payment for evaluation services. One of the provisions in section 17(a) of the Bill authorizes payment of the cost of evaluation services to SSDI beneficiaries from Social Security Trust Funds. when reference was made in the Bill to evaluation services under section 103(a)(1) of the Rehabilitation Act, perhaps the Bill drafters did not mean to include services of extended evaluation which can be provided for up to 18 months, as defined in section 7(5)(G) of the Rehabilitation Act. These latter services are more costly and involved than the normal SSDI beneficiaries evaluation services and I believe, should be paid from Social Security Trust Funds only where the final outcome of the services would result in a successful rehabilitation as defined in section 222(d) of the Social Security Act.

II. PROGRAM FOR TERMINATED SSDI BENEFICIARIES

Section 17(a) of H.R. 5700 also establishes a two-year program to be administered by the Commissioner of RSA for the purpose of making vocational evaluation and job placement services more readily available to individuals whose entitlement to SSDI benefits was terminated by reason of medical recovery. Many of these medically recovered beneficiaries would no longer meet the definition of "handicapped individual" under the Rehabilitation Act and services to these individuals would need to be provided under arrangements outside the Rehabilitation Act. Along these lines, it is appropriate to note that the Administration will soon propose a consolidation of authority under the rehabilitation Act. The draft Bill is not yet final, however, we will strive to assure that the proposed changes in the rehabilitation provisions of H.R. 5700 are consistent with the Social Security Act.

In conclusion, Mr. Chairman, the Rehabilitation Services Administration is prepared to work with the Social Security Subcommittee. Thank you for your very gracious invitation for me to comment on this proposed legislation. I will be pleased to answer any questions in writing.

STATEMENT OF HON. GENE CHAPPIE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. Chairman, thank you for the opportunity to present testimony before this Committee. I had wanted to introduce Mr. George Watters of Ability Information Systems, but due to prior commitments, I was unable to be here.

As I am sure you are all experiencing, my office has been inundated with correspondence concerning the crisis surrounding the social security system. Many of the questions and casework we receive revolve around the social security disability program. We, in Congress, must actively seek to resolve the concerns of our constituents regarding social security.

One road we must embark on, is to reduce the many unnecessary costs of the program. We must close the holes of the system to make sure that only those who are eligible to receive benefits actually do so. As I am sure you are aware, there is evidence that points to an enormous number of persons who are receiving benefits who should not be.

In the disability program itself, only one out of 16 persons who are referred to rehabilitation programs, actually get off the disability roles. And, only one out of 55 persons who receive disability benefits, return to work. While we must ensure benefits to those who cannot provide for themselves, we must also keep people from collecting benefits as an easy and tempting option. The Administration estimates that up to $4 billion is spent annually to recipients of disability benefits who could actually be employed.

At a time when the entire nation is concerned with cutting costs, this Congress should be willing to consider proposals that would reduce any unnecessary expenditures. And, in order to provide better services for those dependent on Disability Insurance, the Congress should encourage the development of better management techniques. I think it is time we looked at more effective ways of determining eligibility in order to make sure that people who cannot secure employment because of their disability are served, and at the same time ensure that those who can be rehabilitated reenter the work force.

Mr. Watters has developed a system that he says would improve the administration of the Disability Insurance program and reduce costs by $2 billion. A proposal of this nature deserves the full attention and consideration of this Committee. I believe we owe this much to the taxpayers of this country.

STATEMENT OF HON. STEPHEN L. NEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH CAROLINA

Mr. Chairman and members of the subcommittee, I appreciate the opportunity to submit testimony before this subcommittee on a most tragic situation.

The situation involves the Social Security Administration (SSA) and its administration of the disability insurance program. Let me share some of the incidents which have occurred in my congressional district:

A middle aged man with a very severe back ailment and who for the past ten yers has received social security disability payments, was terminated from the program without ever having a current physical examination.

A leg amputee, who is currently receiving treatment for pain in his limb, was informed by the Social Security Administration that his benefits were being terminated and that he was able to work. His body, however, has been unable to accept the artificial limb because of pain.

A young father of four with heart problems was told by a personal physician he would be risking a possible heart attack if he engages in strenuous work. The Social Security Administration informed him that his benefits were being terminated on the grounds that he could work two to four hours a day at a parking garage. Yet, no such employment opportunities exist in the area.

A mental patient found her only source of income abruptly halted in August, 1981. It took the Social Security Administration over five months to make a decision on her appeal. It will be another three to four months before the case comes before an Administrative Law Judge.

A gentleman, upon arriving for a physical examination at a state agency assigned doctor's office, was told by the receptionist that his benefits were being terminated and the examination results would not matter in the decision. She was correct. After receiving a cursory examination, he received a termination notice a few weeks later.

These are not just isolated incidents. My office has received over 100 similar complaints from disability recipients questioning the manner in which their disability review was handled. I am sure many other horrifying stories have been brought to the subcommittee's attention. Reports of mass benefit terminations, administrative blunders and harassment are occurring throughout the country. I also understand the subcommittee has become aware of individuals commiting suicide after learning their disability benefits have been terminated.

Mr. Chairman, the source of this upheaval is not difficult to explain. It can be traced back to March, 1981, when the Reagan Administration more than doubled the cases for the state agencies to review under the Continuing Disability Review process. Under the Social Security Amendments of 1980, the Social Security Administration (SSA) was required to review all disability cases at least once every three years. This was in response to the lack of follow-up of a beneficiary's medical improvement and possible work activity. The Congress, recognizing the need for providing state agencies with enough leadtime to hire and train the additional staff, established January 1982 as the effective date for implementing the three-year review process.

In March of last year, as a result of an Administrative action, the number of cases referred to the state agencies ballooned from about 160,000 in 1980 to over 356,000 in 1981. As you can imagine, Mr. Chairman, the state agencies were not prepared to take on this caseload. The Administrator of my state's Disability Determination Service reported to me that the decision to escalate the CDI procedure has taxed "to the limit our staff and medical community." There is no doubt that the Administration's decision to accelerate the review process has resulted in many deserving people being deprived of benefits.

Of course, Mr. Chairman, a person can appeal a cessation decision, but the process can take up to twelve months to complete. In the meantime, benefits are terminated within a short time after the findings of the state agency are sent to the Social Security Administration. This poses a serious economic hardship for those who have been wrongfully terminated and stand a good chance of being reinstated.

I am sure that there are some people still on the disability rolls who no longer qualify for these benefits. The CDI three-day review is designed to remove these people from the program. But, according to SSA's own data, over 70 percent of those who have lost disability benefits are being reinstated, indicating a serious flaw in the review and termination program, which I hope this subcommittee will correct.

Seeing the need to correct this problem, on January 25, 1982, I introduced H.R. 5325, which could prevent disability benefits from being terminated prior to the exhaustion of the administrative appeals procedure. The only exception would be in cases in which current medical evidence substantiates the termination of benefits and is made available to the beneficiary. The proposal parallels the procedures already afforded SSI Disability recipients. It also provides an incentive for insuring that the same care and quality which went into the intitial screening for eligibility in the program is given to an individual whose case in under a CDI review.

Mr. Chairman, you are to be commended for conducting this investigation into the disability program. Thousands of people are being hurt by the CDI procedure and therefore it is important that we act now. I respectfully request that you and the members of the subcommittee give careful and thorough consideration to the provisions outlined in H.R. 5325 and develop a workable solution to this problem.

Of course, H.R. 5325 is not a cure-all. I hope the subcommittee can persuade the SSA to return fairness and compassion to the CDI process. The inclusion of my provisions or similar language would, however, relieve a great deal of anxiety for those who are truly disabled.

Thank you again, Mr. Chairman, for allowing me to address this issue.

ADMINISTRATIVE CONFERENCE OF THE UNITED STATES,
Washington, D.C., March 31, 1982.

Hon. J. J. PICKLE,
Chairman, Subcommittee on Social Security, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This is in response to your invitation to the Administrative Conference to comment on H.R. 5700, a bill to amend title II of the Social Security Act.

The Administrative Conference has sponsored several studies of procedures under the Social Security Act, and in 1978 we adopted Recommendation 78-2, Procedures for Determining Social Security Disability Claims. A copy of this recommendation is enclosed. The Conference recommendation is addressed to the procedures employed in the Social Security Administration's Bureau of Hearings and Appeals. However, the procedural proposals in H.R. 5700 are addressed primarily to subjects not dealt with in our recommendation, and therefore the comments I offer are rather tentative and in any case must be taken as the views of this Office and not necessarily of the Conference as a body.

1. One of the most significant proposals in H.R. 5700 is to place increased emphasis on the reconsideration of the claim at the State level. To do this, the bill would provide an evidentiary hearing at the reconsideration stage and close the record thereafter. Review by the Social Security Administration would be on the administrative record compiled at the State level, but if a claimant offered new evidence the Social Security Administration could remand to the State to reconsider the claim in the light of the new evidence.

In our 1978 recommendation (Para. C. (1)), we urged that the Social Security Administration close the record after the ALJ hearing instead of permitting the claimant to introduce new evidence while the case was under review by the SSA's Appeals Council. This recommendation was implemented in the 1980 amendments to the Act. However, to take this further step of closing the record at the State reconsideration stage seems to us to raise a number significant problems.

First, it will necessarily turn the reconsideration stage into a somewhat more formal process, one which is likely to make greater demands on the resources of the State agencies and perhaps on the system as a whole. This is so because at present there are approximately 420,000 cases a year which reach the reconsideration stage but only 252,000 which are heard by Social Security Administration ALJ's. Thus, one effect of closing the record earlier in the process is likely to be to increase the number of cases which require evidentiary hearings.

A critical question, therefore, is how well will the State agencies be able to perform these added functions? Unfortunately, we have no guidance on this question other than the way in which State agency employees are performing their present responsibilities. In this regard, a recent survey of Social Security Administration ALJ's indicates that most ALJ's believe that poor case processing at the State level is primarily responsible for the backlog of cases and the high reversal rate at the ALJ level. They indicated that there was an overemphasis on production at the State level, which resulted in a lack of adequate documentation, the major cause of delay at the hearing stage. Moreover, fully two-thirds of the ALJ's polled believed that the quality of decisions at the State agency level was either "deteriorating" or "stable but poor".[1] Furthermore, the existence of an 87 percent affirmance rate at the reconsideration level, coupled with a substantial reversal rate once the cases reach the Social Security Administration, might suggest an incentive structure at the reconsideration level geared against finding the existence of a disabling condition. It generally is thought that a critical weakness of non-adversary or investigative adjudicatory proceedings is the lack of clear incentives to develop and test both sides of a case.[2] Should this proposed change in the appeals process be effected, special attention must be given to the incentive structure at reconsideration, lest reconsideration remain, as it is currently perceived, a rubber stamp proceeding.

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[1] Staff of House of Representatives Subcommittee on Social Security of Committee on Ways and Means, 96th Cong., 1st sess., Social Security Administrative Law Judges: Survey and Issue Paper 53 (Comm. Print 1979).

Shifting the evidentiary hearing to the reconsideration stage may also have implications in terms of claimants' need for legal representation. At present, the ALJ hearing in social security benefits cases is a rather unique proceeding. The Secretary is not represented by counsel and one of the ALJ's functions is actively to assist the claimant in the presentation of his case, especially on those frequent occasions when a claimant does not have the benefit of counsel or of another qualified representative. If the hearing were shifted to the State level and the record closed thereafter, the assistance in case presentation and evidence development now provided by the ALJ would have to be rendered either by state employees or by the claimant's own counsel. Given the apparent tendency in State agencies toward affirming the initial denial of benefits, it is doubtful that unrepresented claimants could expect the same kind of assistance at reconsideration that they now recieve from the Social Security Administration ALJ.

If the evidentiary hearing is to be held at the reconsideration stage, the role of SSA's Office of Hearing and Appeals (its ALJ's and Appeals Council) needs to be given special thought. Since the evidentiary record will be closed at reconsideration, presumably the ALJ will not hear evidence but will merely review the record in the manner of an appellate tribunal, probably with the benefit of oral argument from the claimant or his attorney and a representative of the State agency. This is a major alteration in the role of the ALJ, which is, ordinarily, to preside over the administrative hearing, to be responsible for assembling the administrative record, and to be the initial, and usually the most important, finder of facts. The bill does not specify the standard the ALJ is to apply in reviewing the State agency's action, but even if review is nominally de novo, the fact that the State agency had the benefit of observing the witnesses and the ALJ did not is likely to weigh heavily in any reveiw limited to the administrative record. Indeed, given the nature of the review functions assigned to the Social Security Administration under the bill, it is not clear why specially-tenured ALJ's, selected on the basis of their experience as trial lawyers, need to be used at all. If the principal fact finding role is to be assigned to the State agency, the Social Security Administration's review function would be primarily to monitor decisions for adherence to SSA regulations and policy, to achieve greater uniformity of results and to remedy obvious injustice. Under the present system, this is basically the role now performed by the SSA Appeals Council. Under the new system the reviewing function could be performed by trained SSA review personnel, perhaps organized into a two-tier[3] system of review panels.

In sum, shifting the evidentiary hearing and the compilation of the administrative record to the State level while reserving an administrative review function for the Social Security Administration is certainly a plausible approach, but it has implications for the staffing and structure of the process at both the State and Federal levels which the bill does not seem to have addressed.

2. Section 12 of the bill would establish a new Social Security Court which would replace the Federal district courts as the forum for judicial review of decisions of the Social Security Administration. The new court would be an Article I court, with 20 judges appointed by the President with the advice and consent of the Senate for terms of 10 years.[4] The court would review Social Security Administration orders under the same standard of review now employed in the district courts, including the substantial evidence test with respect to findings of fact. Review from the Social Security Court's decision would be available in the U.S. Courts of Appeals, but would be limited to questions of statutory interpretation and constitutional issues.

The purpose in establishing a Social Security Court is not only to relieve the district courts but also to achieve more uniformity in decisions in review of Social Security Administration cases and consequently a more authoritative body of precedential material, which would in turn have greater effect on the subsequent actions of the Social Security Administration.

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[2] Mashaw, et al., Social Security Hearings and Appeals (1978).

[3] Two tiers would almost certainly be necessary because the case volume, including the required proportion of "own motion" reviews, could not be handled effectively in a single tier of review.

[4] The bill would also provide for the appointment of commissioners by the chief judge of the court, but since the court would review cases on the administrative record, it is not clear what the function of the commissioners would be.

The proposal for a Social Security Court touches upon one of the recurrent dilemmas in the area of judicial review of agency action. In its 1971 statement, in which it commented negatively on a proposal of the President's Advisory Council on Executive Organization (the "Ash Council") for a specialized Article I court to hear appeals from certain of the regulatory agencies, the Administrative Conference set out the competing considerations:

"A traditional justification of limited judicial review of regulatory decisions suggests the appropriateness of a non-specialized court of general jurisdiction. Regulartory agencies have a tendency to become preoccupied narrowly with a limited set of policies and concerns; review of the legality of their actions in the light of the broader perspective of the norms and values of the total legal system may outweigh any benefits from specialization. The function of judicial review, in this view, is not to provide a better expert, but to subject the agency's action to independent scrutiny as to its fairness and consistency with statutory and constitutional norms. The contrary position emphasizes the necessity for expert knowledge and specialized judgment in order to perform a meaningful review function in highly complex regulatory cases. . . ."

While a specialized Social Security Court will probably provide greater uniformity of results than does the present system of district court review, it will be unlikely to provide the breadth of perspective and the degree of detachment which are the chief advantages of judicial review. Furthermore, because one of the court's principal functions is to create a body of precedential material governing subsequent SSA actions, there is a danger that the court may, by degrees, tend to fuse (or confuse) its role with that of the Secretary.

Indeed, we perceive a subtle internal contradition in the proposals in H.R. 5700. On the one hand, the bill seeks to achieve greater uniformity and consistency in results through increased administrative control. To this end section 7 of the bill gives increased emphasis to the use of regulations of the Secretary and the other administrative issuances to govern determinations at every level, while section 6 directs the Secretary to review on his own motion at least 15 percent of the decisions rendered in favor of claimants. We applaud this emphasis on centralized management and control of the adjudicative process, which is generally consistent with Part C of our recommendation. But while sections 6 and 7 strengthen the role of the Secretary (acting, of course, through the Social Security Administration and the Appeals Council), section 12 weakens it, by establishing a specialized court with a mandate to develop a body of precedents guiding administration of the Social Security Act. A collision of these two principles of control seems inevitable if the bill is enacted in its present form.

3. Section 13 of the bill would exempt both administrative proceedings and judicial proceedings under the Social Security Act from the provisions of the Equal Access to Justice Act, Pub. L. No. 96-481, §§ 203, 204. That statute provides for recovery of attorney fees by private parties who prevail in litigation against the United States, where it is determined that the position of the Government was not substantially justified. The Equal Access to Justice Act does not at present authorize fee awards in administrative proceedings under the Social Security Act, since these proceedings are not regarded as "adversary adjudications" within the meaning of Section 203 of the Act. However, the procedural changes provided elsewhere in the bill, particularly the shift of the evidentiary hearing to the reconsideration stage, may cause the proceeding to become adversary within the statutory definition. It may be, therefore, that Congress would wish to exclude Social Security hearings expressly from section 203 of the Equal Access to Justice Act, since that section is otherwise largely limited to administrative proceedings instituted by an agency and of an accusatory nature. Section 204, however, authorizes award of attorney fees in civil litigation against the United States. It is not limited to actions which are brought by the United States, nor is it limited to cases involving any particular subject matter. While we agree that given the multiple levels of administrative review available to a disability claimant under the Social Security Act, it is unlikely that there would often be circumstances justifying a fee award under section 204, nevertheless it seems incongruous to exempt this category of case from the otherwise generally applicable rule set forth in section 204.

I appreciate this opportunity to comment on the provisions of H.R. 5700.

Sincerely yours,

LOREN A. SMITH,
Chairman.

[Attachment]

RECOMMENDATION 78-2—PROCEDURES FOR DETERMINING SOCIAL SECURITY DISABILITY CLAIMS

(Adopted June 7-8, 1978)

For at least two decades the Social Security Administration's hearings and appeals processes, particularly those for determining disability claims which account for 90 percent of all hearings, have been the subject of study, debate and critical comment. Suggestions for improvement of these processes abound. It has been proposed that Social Security hearings be exempted from the formal hearing requirements of the Administrative Procedure Act; that administrative law judges not be used to decide these cases: that the decisions be made not after "hearing," but after "examination" by a panel of experts: that the hearing process be retained, but made fully adversary; that one or another level of agency review be abolished; that judicial review be precluded or shifted to magistrates or to an Article I court; that the substantive standard be changed, or at least sharpened by the development of regulations or precedent decisions.

The National Center for Administrative Justice has recently concluded the most comprehensive study yet undertaken of the Social Security hearings and appeals system. In developing the present recommendations, the Administrative Conference has reviewed and built upon that study, the general conclusion of which is that, given existing information, the more dramatic proposals for reform of the system are inadvisable. While the problems that have been identified by others do in various degrees infect the Social Security hearings and appeals system, the difficulties are not so overwhelming that the proposal of a markedly different system is required. Hence the recommendations that follow are for the most part interstitial and conservative. Their purpose is to prescribe improvements while reinforcing sound practice.

RECOMMENDATION

A. Decisional body

1. The use of administrative law judges appointed in conformity with the Administrative Procedure Act to decide disability claims should be continued.

2. The Bueau of Hearings and Appeals (BHA) possesses and should exercise the authority, consistent with the administrative law judge's decisional independence, to prescribe procedures and techniques for the accurate and expeditious disposition of Social Security Administration claims. After consultation with its administrative law judge corps, the Civil Service Commission, and other affected interests, BHA should establish by regulation the agency's expectations concerning the administrative law judges' performance. Maintaining the administrative law judges' decisional independence does not preclude the articulation of appropriate productivity norms or efforts to secure adherence to previously enunciated standards and policies underlying the Social Security Administration's fulfillment of statutory duties.

B. Evidentiary development

1. Although evidence must sometimes be collected after the administrative law judge hearing, prehearing development often may be necessary for an informed and pertinent exchange at the hearing. Administrative law judges should not therefore adopt an invariant policy of post-hearing development, but should develop the record during the pre-hearing stage whenever sound discretion suggests that such development is feasible and useful.

2. The Bureau of Hearings and Appeals should experiment with wider use of prehearing interviews as a means for case development and in order to provide increased opportunity for grants of benefits without the necessity of a hearing. Due regard should be paid to the convenience of the claimants and to the need for a suitable record of such interviews.

3. Better use should be made of treating physicians as sources of useful information. In this regard, Bureau of Hearings and Appeals should make more frequent use of available, standard form questionnaires to treating physicians. And when the Bureau of Hearings and Appeals finds that consulting physicians' reports conflict with evidence supplied by treating physicians, it should inform claimants of the opportunity to have their treating physicians comment in writing on the consulting physicians' reports.

4. The Bureau of Hearings and Appeals should make better use of claimants as sources of information by (a) providing them with available state agency reasons for

denial; (b) providing notice of the critical issues to be canvassed at the hearing; and (c) engaging in careful and detailed questioning of the claimant at the hearing.

5. In the absence of regulations structuring the administrative law judge's discretion when evaluating vocational factors, administrative law judges should take official notice at the hearing of vocational facts that can be established by widely-recognized documentary sources or on the basis of agency experience.

6. When vocational experts are called as witnesses they should be examined in detail concerning (a) the claimant's job-related skills; (b) the specific jobs that exist for persons with the claimant's skills and functional limitations; and (c) the number and regional location of jobs that the claimant can perform.

7. Claimants should not be asked to waive their rights to see evidence developed after the hearing.

8. Congressional inquiries should be processed by Bureau of Hearings and Appeals offices in a manner that will avoid any suggestion of preferential treatment of claimants either in the scheduling or outcome of hearings.

C. Monitoring, management and control of the hearing process

1. The Appeals Council should excercise review on the basis of the evidence established in the record before the administrative law judge. If a claimant wishes to offer new evidence after the hearing record has been closed, petition should be made to the administrative law judge to reopen the record. Where new evidence is offered when an appeal is pending in the Appeals Council, the Appeals Council should make that evidence a part of the record for purposes of the appeal only if a refusal to do so would result in substantial injustice or unreasonable delay.

2. The Social Security Administration should devote more attention to the development and dissemination of precedent materials. These actions include: (a) regulatory codification of settled or established policies: (b) reasoned acquiescence or nonacquiescence in judicial decisions; (c) publication of fact-based precedent decisions; (d) periodic conferences of administrative law judges for discussion of new legal developments or recurrent problems.

3. The Bureau of Hearings and Appeals should continue an aggressive quality assurance program to identify errors, determine their causes and prevent their recurrence.

D. Judicial review

When seeking a "Secretary-initiated" remand, pursuant to Section 205 of the Social Security Act, the Secretary should state the reasons for such request.

E. Representation

1. Bureau of Hearings and Appeals offices should fully inform claimants prior to the hearing of the availability of counsel and lay representation and of the means by which they may obtain counsel or representation in their local area on a fee or no-fee basis.

2. The Bureau of Hearings and Appeals should assist and cooperate with appropriate organizations in the development of training programs for attorneys and lay representatives.

American Council of Life Insurance,
Health Insurance Association of America,
Washington, D.C., March 23, 1982.

Hon. J. J. Pickle,
Chairman, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman: This is in response to your invitation to the American Council of Life Insurance and the Health Insurance Association of America to submit comments on H.R. 5700 relating to the Disability Insurance program. The Council and the HIAA have over 600 member companies which, in the aggregate, write more than eighty percent of the private disability insurance written in the United States.

In general, we agree with the bill's objective of strengthening the disability process by providing for greater uniformity of treatment of individuals and more effective administration of the program.

We strongly support the concept that DI benefits should be confined to those who have had a fairly recent history of attachment to the labor force prior to disability. Present law seeks to achieve this by requiring as a condition for eligiblity for DI benefits that a worker not only be fully insured but also have earned at least 20 quarters of coverage in the 40-quarter period prior to becoming disabled. However, as the summary of H.R. 5700 indicates, this 20-out-of-40-quarters coverage requirement is not adequate and would permit a worker who had left the work force 5 years before becoming disabled to qualify for DI benefits. For this reason, we believe it is essential to impose a stricter recency-of-work requirement for DI benefits through provisions at least as strong as the one in H.R. 5700 which would require individuals to satisfy the additional test of having 8 quarters of coverage in the last 24 quarters (consisting of the year in which the disability began and the 5 preceding years) in order to qualify for the DI benefits. Last year, we supported even stricter recency-of-work tests proposed by the Administration.

We support the changes in H.R. 5700 which extent the worker's compensation offset to age 65 for individuals who became eligible for DI benefits prior to March 1, 1981, and continue the reduction in retirement benefits at age 65 for individuals who previously elected early retirement with concurrent entitlement under DI and OASI.

Finally, we support reasonable incentives to encourage those who suffer impairments to return to work such as the provision in H.R. 5700 to expand demonstration projects to explore how best to use private agencies in providing rehabilitation services to disabled beneficiaries.

We appreciate this opportunity to comment on H.R. 5700 and request that this letter be included in the record of the hearings on this bill.

Sincerely,

KENNETH R. AUSTIN,
Chairman, Social Security Committee, ACLI.
CHARLES E. SOULE,
Chairman, Federal Affairs Subcommittee,
Disability Insurance Committee, HIAA.

STATEMENT OF J. SCOTT MARSHALL, DIRECTOR OF GOVERNMENTAL AFFAIRS, THE AMERICAN COUNCIL OF THE BLIND

The American Council of the Blind is a national membership organization of blind and visually impaired people. Since the Council founding in 1961, we have been actively involved in the development of the Social Security Disability Insurance (SSDI) and the Supplemental Security Income (SSI) programs. We appreciate the opportunity to comment in writing upon Representative Pickle's recently introduced Bill H.R. 5700, the Disability Amendments of 1982.

I. PROVISIONS OF H.R. 5700 WHICH SHOULD BE ENACTED IMMEDIATELY

A. Temporary changes (section 3 and 4)

We commend the Committee for acting quickly to make the changes necessary to resolve the immediate hardship caused to recipients of SSDI who have been terminated as the result of the CDI process. The temporary changes proposed in H.R. 5700 will eliminate some of these hardships. We support passage of the following proposals and suggest they become permanent rather than merely temporary provisions in the Act.

1. Amendments to Section 223 of the Social Security Act waiving overpayments of benefits paid to a claimant prior to the notice of termination. We question, however, the enforceability of the provision concerning "willful neglect" to report a change in medical condition as being difficult to prove.
2. The addition of a four (4) month adjustment period for medically terminated cases.
3. Provisions for vocational evaluation and placement of persons who have been terminated as a result of medical evidence.

B. Permanent changes (section 17)

The American Council of the Blind strongly favors the provision in Section 17 of the Social Security Act which makes it clear that state vocational rehabilitation agencies can be paid in advance from the disability insurance trust fund for vocational rehabilitation services provided to beneficiaries.

II. PROVISIONS WHICH REQUIRE FURTHER STUDY

H.R. 5700 will make substantial changes in the Social Security Program and the due process rights of clients. We urge the Subcommittee to allow more time for public comment and deliberation on these parts of H.R. 5700.

The Subcommittee should investigate further the issue of continuation of benefits through the appeal process as well as the issue of recoupment of overpayment if the claimant loses the appeal. Continuing of benefits through the reconsideration level as required in Section 2 of H.R. 5700 does not go far enough to protect a claimant in situations where the Social Security Administration's initial termination is later reversed. Representative Bruce Vento, in his Bill 5684, has offered one solution to this problem which merits further study. A claimant would have a right to elect to have benefits continue pending a decision of an Administrative Law Judge. If the claimant made such an election and the claimant ultimately lost on an appeal, such benefits would constitute overpayments unless the Administrative Law Judge directed otherwise. Similarly, Senator H. Metzenbaum in his Bill S. 2086 provides for continuation of benefits through the appeals process with recoupment of overpayments limited to claimants whose incomes are in excess of 150 percent of the poverty line. The American Council of the Blind does not take a position at this time as to whether the Vento or Metzenbaum approach is more appropriate.

If the Subcommittee feels it is necessary to mark up H.R. 5700 immediately, we hope that the following provisions can be deleted or substantially modified.

A. Amendments to Section 223(c)(1) of the Social Security Act to add a recency of work requirement of 2 years out of the 6 calendar years immediately preceding the onset of disability should be deleted from the Bill. This provision will operate against the most severely handicapped (such as the blind) who face unique barriers to employment—discrimination for example—which may make it difficult to meet a stringent recency of work test. This is not to suggest that the SSDI program should be a welfare program rather than an insurance program designed to replace earnings lost due to disability. Simply the SSDI program should not compound the economic effects of a disability by requiring a disabled person to meet an unrealistic recency of work standard.

B. Amendments to Section 205 and 221 which would make the reconsideration the most significant stage of the appeals process by, among other things, allowing no new medical evidence at the hearing level. Although the objective of reducing all caseloads is a laudable one, we believe that this goal could be reached by placing more emphasis upon insuring fair and uniform decisions at the initial determinational level. Reversals by Administrative Law Judges could also be reduced by requiring the Social Security Administration to obtain adequate medical evidence at the initial determination stage and by requiring the Administration to follow interpretations of the Law and regulations by the U.S. Federal District Courts at all stages in the decision and appeals process.

Unless the Social Security Administration is required to do these things, it is unfair to the claimant to close the Administrative record at the reconsideration level as proposed in Section 5(5) of H.R. 5700. Claimants are usually not represented by an attorney at the reconsideration level and thus, may be unable to establish a full record at that time. In addition, an inability to present new evidence before an Administrative Law Judge at the hearing stage may operate against the claimant whose condition has worsened since the reconsideration termination period. H.R. 5700 would in such situations permit a remand to the reconsideration level but this means additional delay which would result if the Administrative Law Judge were empowered to review the new evidence.

C. Uniformity of decision-making can be achieved only by adherence to statute and regulations. The Procedural Operations Manual System (POMS) is not subject to public comment as is available under the Administrative Procedure Act in connection with the promulgation of regulations. In addition, the POMS and the Social Security rulings are not generally available to claimants and their representatives as are the regulations which are published in the Federal Register. In addition, as noted above, the Social Security Administration's policy of non-acquiescence to decisions of U.S. District Courts should not be permitted. Accordingly, Section 7 of H.R. 5700 should be amended so as not to require the Administrative Law Judges to adhere to the Procedural Operations Manual System during the appeals and should be further amended to require that the Social Security Administration must follow decisions of the U.S. District Courts in all of its determinations.

The foregoing has been a brief summary of our views as to some of the provisions of H.R. 5700. A copy of this statement will be forwarded to Committee Counsel for inclusion in the hearing record.

American Federation of Labor
and Congress of Industrial Organizations,
Washington, D.C., March 22, 1982.

Hon. J. J. Pickle,
Chairman, House Subcommittee on Social Security, Ways and Means Committee,
Washington, D.C.

Dear Mr. Chairman: We are writing to submit our views to the Subcommittee on Social Security on H.R. 5700, a bill which would modify a number of important features of the Social Security Disability Program.

Our greatest concern is a provision of the bill which would restrict even more drastically the present requirement for recent attachment to the workforce as a condition for disability benefit eligibility. Under present law, the disabled worker must be fully insured and must also meet an additional test of substantial recent covered work. To meet this recency test, a worker disabled at age 31 or later must have at least 20 quarters (5 years) of social security coverage during the period of forty calendar quarters (10 years) ending with the quarter in which he or she becomes disabled. (The law provides an alternative test for workers before age 31 in view of the relatively short time that they have been in the workforce). The bill would require participation in covered work for two out of the last six years in addition to the present stringent recency requirement.

One of the persistent problems in the disability program has been the effect of the recency test in denying benefits to people who were regular workers but whose working ability has diminished gradually because of progressive illness. Such people may experience great difficulty in maintaining steady employment, even though they retain the capacity to engage in some type of substantial gainful activity and are not yet disabled within the stringent definition of the Social Security Law. By the time their impairments progress to the point of preventing substantial gainful activity altogether, the interruption of their work caused by illness means that some of them can no longer meet the test of recent employment, and so are not eligible for disability benefits.

The insured status requirements for disability particularly affect women. Because women frequently have interrupted employment due to child bearing and child rearing responsibilities, most do not qualify for disability protection. Only about fifty percent are covered by disability insurance compared to about 90 percent for men.

In addition, it is discriminatory for the program to deny an applicant disability benefits who does not meet the recency test but is fully insured with possibly forty-five or fifty quarters of coverage, and qualify someone for retirement benefits with a lesser total amount of covered work.

Therefore, we recommend that the present recency test be eliminated. It certainly should not be restricted further as H. R. 5700 would do.

We support the provision that liberalizes the determination of substantial gainful activity (SGA). The current income limit of $300 per month used to terminate benefits should be raised, as the bill provides, so that it is the same as for the retirement test for retired social security beneficiaries under age 65 and then subject it to the same automatic indexing procedures. Similarly, disability benefits should be reduced by one dollar for every two dollars of earned income in excess of the SGA amount. This would provide equality of treatment for retired and disabled beneficiaries and eliminate the current inequity as well as the disincentive that exists because disabled beneficiaries lose all benefits when their earnings exceed $300 per month.

We also support several additional provisions of the bill, although in some instances with some modifications, which would do the following:

1. Allow beneficiaries to have disability benefits continued up through the reconsideration stage of appeal.
2. Continue benefits for four months after the individual is notified that he or she is being terminated for medical recovery, provided they have been on the rolls for 36 months. This is a temporary provision and should be made permanent.
3. Waive overpayments where the date of cessation precedes the date of the notice of termination. This temporary provision should also be made permanent.
4. Improve rehabilitation opportunities for beneficiaries.
5. Authorize the use of trust fund monies for the cost of courses established in medical schools which provide instruction in the evaluation of medical impairments; and create a permanent Advisory Council on the Medical Aspects of Disability.
6. Set payments for consultative medical examinations on Medicare reimbursement principles.

The AFL-CIO is deeply troubled about the Reagan Administration's Continuing Disability Investigations (CDI) which are arbitrarily denying social security benefits to thousands of severely disabled people. In an effort to cut social security disability expenditures, the Administration is putting pressure on administrative law judges and social security personnel to quickly produce a substantial reduction in disability rolls. The result, whether intended or not, has been arbitrary, callous and often illegal treatment of thousands of severely disabled Americans.

H. R. 5700 has a number of provisions designed to assist these victims when a decision to terminate benefits is made. Though helpful to some recipients, these provisions are woefully inadequate to meet the CDI crisis. Due to the enormity of the problem, we respectfully request that your subcommittee schedule a separate hearing to investigate the situation.

As H. R. 5700 is now drafted, its adverse impact would outweight its beneficial provisions. Therefore, we oppose its enactment without substantial modifications along the lines we have suggested. In addition, the Administration has stated it will not propose any changes in the social security system (OASDI) pending the report of the National Commission on Social Security Reform. This commission was recently appointed by the President to study and to make recommendations on the social security program. The Congressional leadership of both parties cooperated in this effort by naming ten of the fifteen members. Thus, we believe the Subcommittee and Congress should not act until the commission has made its report.

We respectfully request that this letter be made a part of the hearings held on this legislation.

Sincerely yours,

RAY DENISON,
Director, Department of Legislation.

NEW YORK, N.Y., *March 15, 1982.*

Hon. J. J. PICKLE,
Chairman, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR SIR: the following comments are offered by me in connection with H.R. 5700 proposing disability amendments for the year 1982. In this connection I wish to mention that I have practiced before the Social Security Administration for approximately the past twelve years handling a very considerable number of cases, mostly in the disability area.

On March 19, 1982 I received your release designated P.R. No. 17 and thereafter proceeded to secure corresponding pages from the Congressional Record of March 3, 1982 elaborating upon the various areas of proposed amendment as shown in your release.

Unfortunately, the limitations of time under which written commentary must be submitted does not permit of the deep analysis which this area deserves. Nevertheless, having given careful consideration to the proposed amendments I offer the following remarks for the record of the hearing, hopefully to be included with the Committee print. This commentary is organized in the same order in which the various proposed changes were discussed in the Congressional Record.

DISABILITY TERMINATION PROCESS—TRANSITION BENEFITS AND SERVICES

I note that the Committee is considering, in connection with termination cases, instituting an evidentiary hearing procedure at the state agency level to be handled either through the state agency or in the alternative the Social Security Administration District Office. I respectfully submit to you in this regard, based upon my many years of experience that the personnel at these levels of administration for the most part neither have the ability, background nor the training to conduct such proceedings in any worthwhile manner. While many of these individuals are highly competent for the job that they now do in connection with the processing of claims, this proposal would have the effect of turning these people into quasi Administrative Law Judges who would pass upon the claim much in the same manner as is now the case at the hearing level. This to my mind, would create substantial problems both as to the individual's technical competence to deal with and assimilate information presented by counsel or otherwise, in addition to creating morale problems among those who feel that they are executing the ALJ's function without recognition and/or pay status. Thus, it is my feeling that the quality of the determination obtained at this level would be questionable and would only further tend to encumber the now already encumbered process which is encountered at the reconsideration stage having received a great deal of criticism in the past.

I further note it is your intention to have those on the rolls for at least 36 months, who are terminated receive something in the nature of four months adjustment pay. I certainly do believe, that this provision is a step in the right direction as there are many who unjustifiably have their lives interrupted by the termination procedure and actual termination of benefits which appears, from where I sit, to be nothing but a numbers game in an attempt to reduce the rolls of beneficiaries, despite the apparent continuing entitlement of such individuals. I have many times over in practice witnessed the termination of benefits for those who actually have and continue to meet the Listing of Impairments as promulgated by the Secretary. I further believe, that in such instances the waiver of overpayments which you suggest is very much warranted. I further consider it a good idea, at least in theory, to refer such individuals (where true medical improvement has taken place) to the Office of Vocational Rehabilitation for a realignment and reassessment of their lives and productive worth.

However, with respect to all of this, some provision must be made to allow those with permanent impairments initially entitled to disability, to go through life undisturbed by repeated reviews in light of the fact that the condition is not amenable to improvement and a review would serve no purpose. Thus, some assessment must be made as to the character of the impairment upon which the finding of disability rests, with careful guidelines drawn to determine under what circumstances notice can be taken that disability continues. Failing this, a review of these cases will undoubtedly only produce administrative waste and great anxiety as well as economic hardship to those being reviewed. I am most sincerely hopeful, that the Committee will give careful consideration to this aspect of the matter as well.

STRENGTHENING THE RECONSIDERATION PROCESS

In this connection, you have noted that amendments of 1980 have eliminated the introduction of new evidence at the Appeals Council level. It is further suggested that by closing the record for the introduction of new evidence at the reconsideration level, that level of administrative proceeding will be strengthened as the result of attorneys in particular having been given impetus to present their evidence so that the case may properly be adjudicated prior to the time of hearing. In response to these suggestions, I can only say that limiting the evidence which may be presented in someone's behalf by closing the record for this purpose at this reconsideration level is another giant step backward in the disability program which will undoubtedly be calculated to yield further poor results, waste, and a host of problems larger in scope than that or those sought to be solved. I can only state on the basis of my own experience that while I have never withheld evidence available to me at the reconsideration level for the purpose of perpetuating the claim, the submission of clear and persuasive evidence at this stage of the proceeding as at the initial stage has by and large proven to be without value in obtaining a favorable result. Essentially, the reason for this is that the state agency in New York in evaluating these cases uses standards other than those upon which these cases are to be adjudged and other than those correctly applied by the Administative Law Judges. In particular, I have noted over the years that the state agency is not impressed with either a claimant's own statement; any degree of pain that a claimant may suffer; or any vocational limitations, other than the grossest, which an individual may have. Rather, the state agency looks to whether or not an individual meets the so-called "Listings" and even when an individual does so, very often the state agency misses the point. Or, if a disability analyst for the state agency does see the forest for the trees, more often than not, the state physician reviewing his action will negate any possible allowance of benefits at this level. It is this unrealistic manner of proceeding, which has led to the horror which you now seek to correct in a manner not calculated to do so in my opinion.

Further, in respect of proceedings beyond the reconsideration level, I must call to your attention and cannot sufficiently emphasize the fact that the physical processes causing disability in most individuals are on going and progressive and as such may require further or supplementary documentation as the claim progresses. To foreclose an individual from so doing, in my opinion raises very, very serious constitutional questions as to the elementary fairness of the proceeding in which an applicant for disability benefits is involved. Indeed, to say that this matter is easily taken care of by permitting the individual to file a new application after the reconsideration level in the event that his or her condition worsens is fallacious and wasteful. It is utterly clear to me, that such a matter coming before an Administrative Law Judge or even the Appeals Council ought to be adjudged with great care, not only on the basis of past information available, but as well on the basis of current information which may in retrospect make it clear that the individual was initially disabled although such were not the prior findings. In terms of pure effort and cost, it seems to be that the proceedings become much more costly and involved when an individual is required to again refile the same paperwork as was filed initially and out the same cumbersome bureaucracy through the same steps as could have been avoided by permitting either an Administrative Law Judge and even the Appeals Council to take cognizance of the present condition with adequate documentation. To suffer one not to introduce further evidence at the hearing level, (held some four to six months after the reconsideration) would severely limit the scope of the inquiry and vitiate all questioning as to the then present status of the individual's condition.

Likewise, to state that the Administrative Law Judge, if new evidence is presented could in addition to requiring an applicant to file a new application, remand the case to the state agency adds nothing whatever to the Secretary's regulations which are now in effect. In this connection, your attention is drawn to section 404.941, 20 CFR vesting in a hearing officer the right to remand a case for a so-called pre-hearing review by the state agency. Inasmuch as this right already exists by virtue of regulation, it is my considered feeling that legislation in this area is totally unnecessary. If the desire of the Committee is such as to relieve some of the pressure on the ALJs, perhaps you might care to consider that there may very well be an insufficient number of ALJs as well as courtrooms and support staff in relation to the number of cases being heard and determined. The New York (Borough of Manhattan) Hearing Office is a case in point. In that office, there is utterly no place for an attorney to sit and talk with his client and/or a witness with any measure of privacy. Indeed, on many occasions there are not adequate seats for severely impaired individuals who cannot bear the burden of standing in anticipation of a case being called by the judge with whom it is scheduled. Recently, new judges have been added to this hearing office for the purpose of disposing of many of the backlogged cases. This has led to the unfortunate situation of having new judges without support staff to assist them in handling their case load. This of course is an impossible situation, however neither staff nor the funds to hire them are readily forthcoming. Further, it should be noted that there are too few courtrooms in Manhattan for the numerous judges who must hear cases. This leaves the ALJs in the unhappy position of either having to hear cases in their office or occupy courtrooms on a time shared basis such as to reduce their efficiency and effectiveness. It also has the most untoward effect of making it impossible for counsel in certain instances to produce medical witnesses in support of the claim for benefits. For example, some judges have stated that the courtrooms are only assigned to them during the morning hours and accordingly cannot hold a hearing at such time as would permit a medical witness who could appear only during the afternoon hours to testify. I personally find this to be most unfair and utterly absurd from a practical standpoint. In the first place, there are some medical witnesses and/or other witnesses who just cannot appear at certain hours of the day. It is clear to me, that to preclude the production of such witnesses for the purpose of enlightening the judge and the record is to derogate a claimant's constitutional right to have a claim adequately heard. Thus, without further undue elaboration, I ask that you look into this most unfortunate area of practice before the Administration in connection with certain of its hearing offices. I further request, that your committee take appropriate action either through legislative means or otherwise to vitiate these abhorrent circumstances which create much greater hardships for the ALJs than having to deal with currently produced evidence at the time of hearing.

Further, before closing comment with respect to this subheading, it appears that some consideration is being given to having a state agency physician or consultative physician supply the assessment of residual functional capacity. In this respect, I must call to your attention that these individuals may not have any contact with the claimant at all or if they do, it is at best extremely brief. It seems to me, that the residual functional capacity of any given individual ought to be supplied by the treating physician who has the greatest exposure to the individual and familiarity with the medical condition.

OWN-MOTION REVIEW

I note that there is a provision in the bill to currently review 15 percent of ALJ awards and reversals of cessations and in future years to review 35 percent of them. In this connection, I am most struck by the fact that apparently the committee does not consider it worthwhile to require that the same percentage of decisions representing denials as well be reviewed. Certainly, it appears to me that the area of denials is as much a part of the desire for a uniformity in decision making as is the area of allowance. Further, it appears to me that an equal amount of error can reasonably creep into the bases upon which a denial is made and that indeed many of the denials may be revised to an allowance if accurate and uniform standards are applied. Accordingly, it is requested that you amend the bill to state that 15 percent of all ALJ decisions will be reviewed and likewise 35 percent of them in future years will be reviewed, with the review encompassing equal numbers of denials and allowances. Certainly, it seems to me that for the Administration to focus their attention on anything less than a fair split of denials and allowances would lead to claims of constitutional magnitude concerning the undue scrutiny of a particular class of decisions.

ADJUDICATED GUIDELINES AVAILABLE AT ALL LEVELS AND DEFINITION OF PAIN

I respectfully submit, that the adjudicated guidelines referred to in the Congressional Record are presently available and in the possession of the stage agency, however the problem to be overcome here is in getting the state agency to apply these guidelines in a fair and equitable manner. As noted above, the state agency tends only to concentrate on the actual listing of impairments, without reference to any other guidelines that may be available including Rulings and the medical-vocational guidelines to be found in appendix 2 to subpart P of 20 CFR.

As regards pain, it is my opinion that the committee ought not to recommend and the Congress ought not to adopt any legislation whatever in this area. Indeed, I should think that the Congress would not want to do so anymore than Mr. Lincoln our 16th President was willing to offer an opinion as to how long a man's legs should be. Further, one need only read the magnificent language in *Ber* vs. *Celebrezze,* 332 F.2d 293 (2d Cir. 1964). The court then speaking through Judge Waterman offered the following magnificent language elucidating this complex area:

"The critical issue in this case was one which could not be resolved merely by determining what objectively observable physical changes had taken place in Mrs. Ber's bone and muscle structure as the result of her arthritic condition, and then placing these observable changes alongside other similar changes in other persons so as to measure arthritic conditions on an imaginary scale with calibrations ranging from the word 'mild' to 'severe'. *The ultimate question was whether the arthritic changes which had taken place in Mrs. Ber's body did, in view of her individual physical and mental makeup, cause pain which became so intensely severe to her that, as she testified, it forced her to quit working.* Whatever the probative value on this issue of normal reactions to objectively observable physical symptoms, it is common knowledge that physical phenomena of a debilitative nature may work differing degrees of hardship on different persons; and too, that even where the amount of hardship experienced is roughly the same, persons subjected to it will bear up differently because they possess relatively higher or lower thresholds of resistance to the pain that debilitation generates. *What one human being may be able to tolerate as an uncomfortable but bearable burden may constitute for another human being a degree of pain so unbearable as to subject him to unrelenting misery of the worst sort.* Indeed, inasmuch as the applicable section of the Social Security Act requires a showing of medically determinable physical or mental impairment, even pain *unaccompanied* by any objectively observable symptom which is nevertheless real to the sufferer and so intense as to be disabling will support a claim for disability benefits. (Citations omitted and emphasis supplied)."

Thus, I believe that the United States Court of Appeals for the Second Circuit has stated the prevailing view in these United States with respect to pain and that the Congress ought not to legislate or attempt to legislate this decision and its holding into oblivion.

MEDICAL SCHOOL COURSES AND CONTINUED EDUCATION IN DISABILITY

It is my firm belief, that while those adjudging these cases should be medically knowledgable enough to understand the nature of the impairment with which they deal, submitting these individuals to medical school courses is unwarranted and in my opinion wasteful. It occurs to me, that many of the individuals who would be subjected to these courses, might have an inadequate background to deal with the information that must be assimilated in certain technical and specialized fields of medicine. Indeed, we ought not to turn lay personnel into quasi medical doctors for the purpose of adjudicating these claims when indeed licensed medical doctors are available to make such technical determinations. If it is your intention, to maintain and sharpen the skills of licensed medical practitioners in various areas, I have no quibble with this. However, if it is your intention with this proposal to turn lay personnel into quasi physicians I feel a great deal of trepidation in encouraging you to so proceed as the inevitable result may prove the old maxim that a little knowledge is a dangerous thing.

JUDICIAL REVIEW

I have noted with interest your proposals concerning the establishment of a Social Security Court. Obviously, one of the prime targets in establishing such a judicial body would be to eliminate inconsistent judicial precedent. However, it is my feeling that this goal will not be realized as inevitably this court will sit in different locations throughout the United States and may in and of itself produce conflicting decision. Further, even though the court itself may produce a greater measure of consistency in the decisions that it renders, then do diverse U.S. District Court, it is my feeling, that appeals of these decision to the various circuits may result in an equivalent hodge-podge of dissimilar decisions casting at least equivalent doubt over what the holding should be in any given case on a particular set of facts. In any event, if it is intended that all appeals from this court shall be made to the U.S. Circuit Court of Appeals for the District of Columbia, it is my considered opinion that spearheading all of the appeals to one judicial forum would inevitably create such an utter backlog and overload within that particular court as to materially reduce the quality of justice and/or render the system totally unworkable.

Rather, it is my idea that the individual District Courts should receive the appointment of additional judges who would handle as their sole calendar the many Social Security cases which are now backlogged in many of the courts and which require attention and disposition. In this manner, it will not be necessary to create a separate court, nor will it be necessary to give these cases a preference ahead of other cases which come before the numerous United States District Judges presently sitting. It is further my feeling, that those United States District Judges appointed under this proposal could readily establish a nationwide conference for the purpose of promulgating guidelines concerning the disposition of these matters. Certainly, if there are areas of material conflict in respect of the holdings in these cases, the Congress is in a position to legislate upon due and diligent inquiry in those areas that require a uniform approach.

Ultimately, in reading the remarks contained in the Congressional Record it is unclear to me what is to become of the numerous pending District Court cases if the power of remand is removed from the hands of the United States District Judge. Quite clearly, there are some abuses and erroneous decisions which require remand rather than outright reversal. If the intent of eliminating the power to remand is such as to make the District Judge's decision an all or nothing proposition, I respectfully submit that this will do great violence to the scope of judicial review new extant. In plain English, there are some cases that go to the U.S. District Court which permit of neither an affirmance of the Secretary's action nor an outright award of benefits. To enact the legislation which you propose would create a great void unfilled by any substitute legislation.

ATTORNEYS' FEES

It is stated in the Record that the Administration's proposal for change of the method in which attorney's fees are dealt with is under active consideration by you. I most strongly urge in this area that a new system be adopted for dealing with the fees for attorneys. Clearly, mentally competent adults ought to be free to agree with their attorneys regarding the amount of any fee payable to an attorney for his or her services. All too often, the present system breaks down in many respects. Initially, it must be considered that many of the individuals evaluating the worth of an attorney's services have little in the way of qualifications to do so. Actually, many have unrealistic ideas as to what an adequate fee is especially considered in light of today's ever increasing inflation and the abominable and abysmal cost of conducting the everyday affairs of a law practice. This is especially true, when a salaried individual is authorizing a large fee for an attorney which represents a substantial percentage of that individual's salary. One who has not been in business or who has not kept in touch with the cost of doing business, is very clearly unprepared to view and assess the realities of a law practice and make an adequate dollar determination as to the worth of any given services. Moreover, in many instances the fixing of a fee falls into the hands of an ALJ or a Regional Chief ALJ who is less than fond of the attorney making application for the fee. In those instances, not only is the decision susceptible of the same pitfalls as those already mentioned, but may take on a punitive character as well. Thus, an attorney vigorously representing an individual may incur the ALJ's wrath and kiss his compensation good bye even though his client may consent to it and actually desire that he be so compensated. Further, any disallowance of a portion of a fee to which a client has agreed constitutes a most mysterious action for the client and may lead him to believe that the attorney has done his work improperly even though this is not the case. As well, it may undoubtedly lead to pitting otherwise satisfied client against his attorney, when a client realizes as the result of this most untoward and unsavory system that there is economic gain to be derived from disputing the fee to which he had originally agreed with the attorney.

In short, there are numerous pitfalls to this system, which have in many instances caused attorneys to be treated unfairly and may have caused severe economic loss. I therefore urge you most strongly to give adequate consideration to this area of change as there is certainly machinery presently existing both within the Social Security Administration (Inspector General's Office) and without (Bar Association Grievance Committee) to police those few attorneys who might exact an unconscionable fee or be engaged in some measure of overreaching.

It is my feeling however, that if regulation in this area is sought it ought to be limited to overseeing the fees of nonattorney representatives who are not accountable to the Bar Association and who do not subscribe to the rather stiff code of ethics by which lawyers are bound. Indeed, the initial legislation undertaken for the regulation of fees was directed at this particular area of representation and not representation by attorneys who as aforementioned are subject to regulation through other means. In sum, this particular area of practice has become in many instances a living nightmare which requires the urgent attention of your committee and ultimately the Congress. To characterize the system as paternalistic is at the very least the understatement of the year.

I do not believe that this area of law ought to be exempted from the provisions of the equal Access to Justice Act as to do so would leave those individuals for whom there was little if anything in retroactive benefits coming, without representation by competent and experienced counsel—or any counsel for that matter.

RECENCY OF WORK REQUIREMENT FOR DISABILITY INSURANCE BENEFITS

I feel that your proposals in this area would affect a relatively small percentage and number of claimants and therefore would not be of great concern to the majority. Nevertheless, there is a small number of claimants and potential claimants who would be directly affected in an adverse manner by such legislation. Inasmuch as the courts have uniformly recognized that the Social Security Act is a remedial statute with beneficient purposes aimed at inclusion rather than exclusion, I would very seriously oppose any further limitation or the enactment of more stringent requirements for qualification.

SUBSTANTIAL, GAINFUL ACTIVITY IN TRIAL WORK

I favor your proposals in this area.

MEGACAP

It is my considered opinion that where an individual has made both contributions to the Social Security System and as well contributed to a pension plan which provides for a disability retirement, that said individual ought to be entitled to the benefits of both without offset or exclusion by either one for benefits provided by the other. Clearly, an individual may purchase two different policies of insurance which would provide the same coverage and duplicate payment. Nevertheless, having paid the requisite premiums such an individual is entitled to reap the benefits of both coverages. This is especially true in the instant situation where Social Security contributions are not made on a voluntary basis but rather are compelled by reason of law. This area raises most interesting questions perhaps of constitutional dimension.

REPEAL OF THE AVERAGE MONTHLY WAGE METHOD OF COMPUTING ACE IN OFFSET PROVISIONS

As regards this area, it appears that although the average monthly wage computation may be beneficial in certain instances, the bill seeks to do away with it primarily because the Administration's automated system is incapable of computing the average monthly wage. I find the removal of this benefit repugnant simply because the mechanics of the Social Security Administration's operation is such as to create problems in making the computation. It is my feeling, that the Administration ought to update or modify its system in such a way that this computation can be made as easily as others and if it cannot do so, I see no reason to penalize any recipient of benefits.

PAYMENTS FOR DI CONSULTATIVE MEDICAL EXAMINATIONS

In this area, I can only suggest that the state agencies using consultants for the purpose of determining the nature and status of an individual's condition, select their consultants with great care such as to get an accurate and detailed picture of the numerous problems from which a claimant suffers.

In many instances, the physicians selected for this purpose appear very much uninterested in detailing the nature of the patient's condition, but rather in getting something on paper so that they can grind out a relatively high volume of work and make these evaluations economically feasible. Thus, it appears to me that not only care should be taken in selecting such consultants—making absolutely certain that their affiliations are such as would render them impartial in reporting—but as well in paying them an adequate fee so that they could take the necessary time and expend the necessary effort to report fairly, completely and accurately. On many occasions my clients have related horror stories concerning these examinations and the findings relative thereto which could not reasonably have been made based upon the examination conducted. It is this type of problem that ought to be eliminated in whatever legislation is proposed and ultimately passed.

INTERIM BENEFITS

It is my feeling, that it is quite improper for any United States District Judge to order the payment of interim benefits as the law does not so provide. Likewise, while the Administration seeks to effect processing guidelines so that matters will not unduly be delayed, it is my suggestion that whatever bill is enacted ought as well to contain a recommendation that these guidelines may be waived by any claimant and/or his or her representative so that the processing is not unduly hastened to a point where adequate documentation and consideration are not brought to any given claim. Ultimately, what inevitably happens in a situation of this nature is that the Administration becomes so hysterical over their own guidelines or those fixed by a court that they are unable to proceed in any reasonable manner despite the fact that counsel and/or the claimant may waive the processing time and opt for a longer period of time such as to document the claim under consideration. It is hoped, that whatever processing times are adopted in this regard, that reason will prevail and that all will be given an adequate opportunity as aforementioned to make a persuasive showing.

In conclusion, I have attempted within the constraints of available time to afford you my views with respect to the various areas of pending legislation.

In this connection, I wish to state that I am not speaking for the most part theoretically, but rather from experience gained over my many years of practice before the Social Security Administration. Accordingly, should you seek documentation in the above areas of comment, upon request, I will be happy to produce such information in my possession as I believe documents any criticisms leveled herein and/or suggestions made. Further, in the event, that you desire to discuss these matters with me personally I shall make myself available to the committtee for this purpose.

Thanking you for your anticipated attention to these lengthy remarks, I am

Respectfully yours,

MARC L. AMES,
Attorney at Law.

P.S. I hereby request and sincerely hope that the committee will forward to me a copy of the actual legislation itself—H.R. 5700. I as well request that upon completion of the study concerning this legislation and any recommendations that may be forthcoming therefrom you will forward to me a copy of the committee print.

ASSOCIATION OF ADMINISTRATIVE LAW JUDGES
IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
March 30, 1982.

JOHN J. SALMON,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. SALMON: Pursuant to the recent press release concerning H.R. 5700 I am providing you with a statement on behalf of the Association of Administrative

Law Judges in the Department of Health and Human Services. I prepared this statement in collabcration with Judge Chester Shatz of Boston, Mass. and Judge Paul Rosenthal of Santa Ana, CA. Judge Alan Goldhammer of Oakland, CA also contributed some useful thoughts.

We appreciate having the opportunity to submit our views on the provisions of this bill, and will be glad to provide any other comments which would be helpful in the legislative process.

Sincerely yours,

AINSWORTH H. BROWN,
Director, Region III,
Association of Administrative Law Judges.

STATEMENT ON BEHALF OF THE ASSOCIATION OF ADMINISTRATIVE LAW JUDGES IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Association of Administrative Law Judges welcomes the opportunity to comment on provisions of H.R. 5700. Some of these provisions will contribute to the improvement in the adjudication system of Social Security claims. There are some which the Association sees no need to comment upon, and others to which we respectfully suggest amendment in order to preserve the fair and independent hearing process which is such an integral part of the fabric of the Social Security system. We suggest that it is time for Congress to reaffirm and express its continued adherence to the principle of the application of the Administrative Procedure Act to Social Security hearings.

The provision for adjustment benefits is an understandable and compassionate method of balancing the interest of claimants and the government in carrying out the Congressional mandate for an effective continuing disability program. Thus, we applaud the idea expressed in Section 3 of the bill, and related provision.

We are also gratified that the face to face interview concept will be encouraged as we have been advocating this process for a number of years. The nature of disability adjudication involves areas of judgment which will be enhanced by seeing the claimant "in person". The provision might well benefit from clarifying language to draw a distinction between the reconsideration interview with capability to receive additional evidence, and the evidenciary hearing, which is the next adjudicative step with the panoply of protections for independent fact finding provided by the Administrative Procedure Act.

Section 16 of the bill is one which may involve an innovative solution to a nagging problem in disability evaluation which has become worse as inflation has continued. We believe that the idea of processing consulting doctor's payments through the Medicare carrier system based on a standard of prevailing charge will allow the State Agencies to purchase better medical evidence. To illustrate the problem, one can look to the situation affecting the Pennsylvania State Agency. The fee for a consultative examination has remained at $35.00 for a number of years despite repeated requests to raise the figure to a more reasonable amount. The fee has remained the same because the governor and interested state cabinet officials have refused to raise it due to the laudable desire of keeping down other state fees for medical vendors. This provision coupled with the changes outlined by the Commissioner of Social Security in his testimony before the subcommittee should have a significant affect on upgrading the quality of consultative examination reports. Many doctors, whether consciously or unconsciously, seem to spend less time on disability evaluations than on other types of consultations.

Section 11 of the bill appears to be rather presumptuous in suggesting governmental involvement in medical school curriculum. However, if this is felt to be desirable by the subcommittee, committee and House, an amendment is suggested to include a representative appointed by the Board of Directors of the Association of Administrative Law Judges (HHS) to the council provided for in this section. Having the benefit of an expert in disability adjudication would seem to be appropriate.

The provisions of the bill which the Association respectfully submit are fraught with difficulty are Sections 5, 7, 8, 12, and 13. Section 5 provides for a revolutionary change in the hearing concept of de novo hearing by closing the record after reconsideration. If the Judge could only remand the matter back to State Agency to consider new evidence the consequent "ping-pong" effect would cause undue delay in reaching a final decision and would, therefore, be a very costly system. For example, suppose a report is received at hearing demonstrating that the cause of vague abdominal complaints has been established as involving a terminal cancer condition—

would it be good public policy to send that case back to the State Agency to consider the new report?

The point needs to be reemphasized that the hearing decision is not an appellate one, but is rather a brand new decision. The prior State Agency determinations are made a part of the record to establish jurisdiction. Changing the character of the hearing decision from a de novo to an appellate one would be a radical departure from the process which has been a part of the Social Security system since its inception. Before any such change would be made extensive hearings should be held to study the due process implications of this provision.

The same point applies to the provision establishing the Social Security Court. The curtailment of access to the Article III judicial system which has been a right of a dissatisfied Social Security claimant for nearly 50 years should not be cast aside without full and careful consideration. While the Social Security Administration has been unhappy with court decisions throughout the years, confidence in the Social Security system has been strengthened by the access of claimants to an independent interpretation of the agency's adjudicative policies and application of the Social Security Act.

The provision respecting attorney's fees when viewed in connection with the reduced availability of legal services representation would significantly circumscribe claimant access to the valuable and constitutionally protected right to legal representation. The existing law providing for a 25 percent withholding for attorney fees insures that claimants can secure lawyers to represent them in highly complex matters. Curtailing this right is both unbecoming, if advocated by the agency, and raises a serious constitutional issue. Typically speaking, claimants have limited education and are often unsophisticated in dealing with "their government". Furthermore, for claimants who have emotional or mental limitations there is an especially important need to have legal representation.

Section 7 of the bill proposes to include the adjudicative standards of the Program Operations Manual System as a binding policy instrument governing the determination of the issue of disability under the Act. For the reasons advanced by the Association last October before the subcommittee this approach is undesirable (see committee print Serial 97-31 at 138 et seq.). The Association believes that if these standards are to be binding on all levels of administrative adjudication that the rule making provisions of the Administrative Procedure Act should be adhered to so that the public will have an opportunity to comment on proposed changes. This will insure that there will be a reasonable degree of uniformity within the regulations themselves and that there will be conformity with the statutory language relating to the issue of disability. While the Social Security Administration is now using the ruling process to accomplish some changes in enunciating disability policy, there are some issues which are so important that they should be exposed to public comment and discussion through rule making.

The concern of the Judges may be fairly put that there is a tendency to make the POMS criteria more restrictive than the criteria expressed in the regulations so that one may be faced with the issue of determining which takes precedence if a conflict emerges. This undoubtedly would develop into a source of friction between Social Security Administration disability policy makers and the Judges which would exacerbate the current tensions without furthering the interests of effective and timely adjudication. SSA's current approach of using rulings is a reasonable approach would be much more desirable for the consideration of public involvement mentioned above.

While we applaud the effort to give more statutory force to pain evaluation, Section 8 is factually defective in appearing to indicate that there are medical tests and procedures designed to quantify and qualify the amount of pain. The art of medicine has not reached that stage as yet. The only thing that medicine can tell us is to identify an impairment which is capable of producing the pain alleged by a person. Much of this process is determined by an integration by the physician of a careful history with pertinent testing and physical findings. We agree that the law should require that a pain producing impairment is a "sine qua non" to the evaluation of pain, but the provision should not go further than that. The provision with proper amendment would have a salutary effect on those courts which indicate that the complaint by itself may be sufficient to support a conclusion of disability.

Under separate cover a suggested amendment has been offered respecting the reaffirmation of the applicability of the Administrative Procedure Act.

Language to be included with the APA applicability proposal also suggests a recognition of the complex nature of the work in the disability evaluation process by placing the job in the GS-16 grade level. This provision would have very little impact in terms of dollars since most Judges are near or at the ceiling for GS level jobs. It would also serve to conserve the valuable resources of the Office of Administrative Law Judges within the Office of Personnel Management by eliminating a portion of its work in processing applications by GS-15 HHS Administrative Law Judges. This change would also contribute to greater flexibility in meeting shifting hearing demands throughout the federal service.

If the Subcommittee desires further discussion of our views on H.R. 5700 we would be glad to accomodate such a request.

AINSWORTH H. BROWN,
U.S. Administrative Law Judge.

CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA,
Washington, D.C., March 19, 1982.

Hon. J. J. PICKLE,
Chairman, Subcommittee on Social Security, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: This letter is in reponse to your recent request for comment by the U.S. Chamber regarding H.R. 5700, the Disability Amendments of 1982.

Overall, we would agree with you that H.R. 5700 is a "good bill". While we are supportive of the general nature of the bill, we do, however, have some reservations about certain aspects of it.

First, we question a need for a Social Security Court. While we agree with your analysis of why some action is needed to alleviate the pressure currently being encountered by the appeals process in Social Security decision making, we do not believe that creating a new judicial forum addresses the underlying cause of the problem of too much flexibility in the law. Thus, the correct solution is to tighten the law's definition of disability and limit determination of that disability to a consideration of medical factors only. As I am sure you remember, the Reagan Administration made a proposal along these lines last May. That proposal, if enacted, would have eliminated many of the subjective judgments which are now required and would, therefore, cut down on the number of appeals.

A second area of reservation concerns the proposal to automatically adjust the substantial gainful activity (SGA) measures. Since the adoption of automatic adjustments, Social Security has become the outstanding example of the hidden perils of indexation. The current program is indexed in seven different areas. While it may be that raising the SGA would be cost-effective in that it would encourage the disabled to seek employment, to tie the SGA amount to automatic escalators is to lose control over that aspect of the program. We should, at this point, be searching for ways to de-index the program, not further index it.

Apart from these two areas, the bill seems quite favorable. We strongly support the tightening of the recency of work section and the worker's compensation provisions. In addition, the sections dealing with uniformity in decision making (own-motion review, adjudicative guidelines, definition of pain and continuing education) are sound and would improve the operations of the program.

Thank you for the opportunity to express our concerns about H.R. 5700 and for your continued leadership on this issue. We would welcome further discussion in this area, should you so desire. And, would appreciate your inclusion of this letter in the hearing record.

Cordially,

HILTON DAVIS.

NEW ORLEANS, LA., *March 23, 1982.*

Hon. J. J. PICKLE,
Chairman, Subcommittee on Social Security, Committee on Ways and Means, Washington, D.C.

DEAR SIR: After your recent oversight hearings on the Office of Hearings and Appeals of the Social Security Administration, a request was made for written comments and suggestions on H.R. 5700.

The undersigned is an administrative law judge with the above organization. In its paper on the operation of the Office of Hearings and Appeals in March of 1979, your committee staff referred to this agency as the "ultimate in Mickey Mouse". These are words of wisdom. It is sad, however, that such an operation should have influence over the rights of hundreds of thousands of taxpayers.

In your 1979 hearings someone presented an affidavit signed by me, and I gave testimony to the effect that the judges in the New Orleans office of OHA had been subjected to intimidation. I would like to amplify my statements of 1979. The administration has denied this intimidation and consistent patterns of conduct. This denial is untrue.

I am attaching hereto: (1.) Freedom of Information Act requests and replies, consisting of Judge Carl Sarett's reports as Judge in Charge to Chief Judge Brown, et al.; (2.) Memorandum of February 25, 1980 of Burton Berkeley to Andrew J. Young, then Associate Commissioner of OHA, showing, in particular, the methods that the Social Security Administration would use to suppress evidence of their intimidating conduct; and (3.) Freedom of Information Act request for judges and offices "targeted" for review under the Bellmon Amendment and the reply thereto.

Comments: Judge Sarett is presently a member of the Appeals Council. Burton Berkeley is presently a factotum on the Appeals Council with the exalted title of Co-Deputy Chairperson.

I have no suggestions; however, I can foresee only massive court intervention in the operation of OHA as ultimate protection of taxpayers' rights under the Administrative Procedure Act.

Sincerely yours,

J. Charles Collins, Jr.,
Administrative Law Judge.

[Attachments]

Department of Health, Education, and Welfare,
Social Security Administration,
New Orleans, La., March 10, 1980.

Mr. Philip T. Brown,
Chief Administrative Law Judge, Office of Hearings and Appeals, U.S. Social Security Administration, Arlington, Va.

Dear Mr. Brown: You will recall your meeting with the undersigned and Administrative Law Judges George M. Ponder and Thomas J. D'Aquila on November 17, 1977 in Arlington, Virginia.

Following that meeting with you and John Poore, the then Administrative Law Judge in Charge Carl Sarett confronted the undersigned and ALJs Ponder, D'Aquila, and Simpson threatening disciplinary action because of our high reversal rates. He stated at that time that he would make periodic reports in writing to you.

ALJ Sarett did in fact make these reports to you in writing in December, 1977 and in January and February, 1978. He sent copies of his correspondence to Irwin Friedenberg, John Poore, Robert Trachtenberg, and Andrew Hickam.

This correspondence is in your records in Arlington on the New Orleans office of OHA.

The undersigned and ALJs Ponder and D'Aquila formally request in the public interest that they be provided with copies of the correspondence described above from ALJ Sarett to you under the Freedom of Information Act, 5 U.S.C. 552 et seq.

Please provide us with this information within the statutory time limit.

Sincerely,

J. Charles Collins, Jr.,
Administrative Law Judge.

Department of Health, Education, and Welfare,
Social Security Administration,
Washington, D.C., April 7, 1980.

Mr. J. Charles Collins, Jr.,
Administrative Law Judge, Office of Hearings and Appeals, SSA, New Orleans, La.

Dear Judge Collins: This is in further response to your request under the Freedom of Information Act. I am enclosing copies of three memorandums from ALJ Carl W. Sarett dated December 5, 1977, January 5, 1978 and February 10, 1978. I believe these are the records to which you referred. Deletions have been made in the documents of personally identifying information in order to protect the privacy of the individuals involved. If you wish to obtain a formal determination on the deletions, we will, upon request, forward the matter to the Director, Office of Information, Baltimore, Maryland for a decision.

Sincerely yours,

Daniel L. Schultz,
Director, Office of Policy and Procedures.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
New Orleans, La., December 5, 1977.

To: Judge Philip Brown, Arlington, Va.
From: Carl W. Sarett, ALJIC.
Subject: Judges, BHA, N.O., La.

I am glad to report that since our visit to Arlington last month there has been no noticeable friction in our office. I cannot say that the other judges are cooperating or not cooperating in any particular respect because I have not asked them to do anything. In fact, other that with Judge Simpson, I have had very little contact with them.

While our office remodeling is not completed, at least we have all our hearing rooms functioning again. The staff has moved into the center work space and they seem to be functioning fairly well without any complaints having been made to me or to the Administrative Officer.

In regard to Judges Ponder, Collins and D'Aquila, I cannot tell if the visit to Central Office had any appreciable effect except that I have not heard of their doing anything especially outlandish since the visit.

In regard to particular ———, the only specific thing noticed were that on two or three occasions in mid-afternoon ————— was seen asleep in —— office with —— feet up on the desk. I do not know if ————— the ————— requested by C.O. ———— called me from ——— to ask if I knew anything of "stories" Judge Collins was telling some judges about —————. I had no knowledge of this.

As you can see by the monthly report for November, the reversal rate continues to be extreme. Judge Ponder granted 24 and denied only 2; Judge Collins granted 23 and denied 7; Judge D'Aquila granted 20 and denied 5. For the record, I was 13 and 14.

The excessive use of VE's and MA's seems to have abated for the month. There was quite normal usage of expert witnesses.

With your permission, unless something of consequence happens, I will forward monthly rather than semi-monthly reports.

CARL W. SARETT.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
New Orleans, La., January 5, 1978.

To: Judge Philip Brown, Arlington, Va.
From: Carl W. Sarett, ALJIC, New Orleans, La.
Subject: Judges, BHA, New Orleans.

With one important exception noted below, I have nothing in particular to report for the month of December 1977. Particularly with the judges taking a great deal of annual leave, it was a quiet month in our office.

I feel compelled, however, to call your attention to the continued incredible reversal rate of some judges here. For the month of December 1977 Judge Ponder affirmed 8 cases and reversed 22. Judge D'Aquila affirmed 4 and reversed 28.

I do not guarantee the absolute accuracy of my figures, but for the year 1977 Judge D'Aquila granted 89.6% of all cases decided by him. Judge Ponder granted 85%.

In 1977 Judge Collins was a bit more moderate, granting [illegible] of his cases. The reversal rates for Judge Simpson and the undersigned were 66% and 41%, respectively.

Whether it is by way of peer review, review by the Appeals Council on its own motion, or otherwise, I would urge that abnormally high reversal rates be "investigated".

CARL W. SARETT.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
New Orleans, La., February 10, 1978.

To: Chief Judge Philip Brown, Mr. John L. Poore.
From: Carl W. Sarett, ALJIC, BHA, New Orleans, La.
Subject: Rumors of Arrest of Mr. Trachtenberg and Mr. Poore.

On Friday afternoon, February 3, 1978, I was told by ————, that Judge Collins had been heard telling members of the staff that Mr. Trachtenberg and Mr. Poore had been arrested by the FBI apparently in connection with alleged "kickbacks" from suppliers.

As I left the office that afternoon about 5:15, I asked Judge Collins what had happened. He stated to me that the FBI had arrested Mr. Trachtenberg, Mr. Poore, and a Mrs. Gardner, who was employed with BHA, in connection with kickbacks from BHA suppliers. He obviously was very happy to relate such information. He was most affirmative and dogmatic as if there was no doubt about the arrests.

He said that it had been confirmed with five different people, obviously meaning that five people had told him of the arrests on the telephone. He also made some rather derogatory remarks about Mrs. Gardner. He added that Mr. Trachtenberg did not have the qualifications for the job as Director and that the only reason he had been kept in the job was "they" were waiting to entrap him in the kickback situation.

I also observed that Judges Collins and ——— were busy on the telephone a good part of the afternoon of February 3rd. ——— even stayed later than ———usual 3:30 quitting time in order to await a telephone call.

On Monday February 6, 1978, in the late afternoon, I asked Judge Collins if he had any further information. Again, he was emphatic as to the arrests. He stated that an indictment had been returned against three people employed or connected with BHA suppliers and that a sealed indictment was to be returned either on February 6 or possibly 7 (frankly, I do not remember which date he mentioned) against Msrs. Trachtenberg and Poore. He added that they had been taken away from BHA Headquarters on Friday afternoon by the FBI and that Mr. Trachtenberg had not been seen at Central Office since then. He did say that Mr. Poore had been seen back at work.

On February 8, 1978, I again inquired of Judge Collins. At this point he did not seem quite as emphatic as previously. He stated that all he knew were the "physical facts"—that Trachtenberg and Poore were taken away by the FBI.

This afternoon, February 10, 1978, I spoke to ———. ——— stated that on the afternoon of February 3, 1978 ——— saw and heard ——— and Collins telling staff personnel that Mr. Trachtenberg and Mr. Poore had been arrested. ——— also stated that ——— had heard Judge Collins on that Friday afternoon telling staff people that the FBI had picked up and arrested Mr. Trachtenberg, Mr. Poore and "his girlfriend".

CARL W. SARETT,
Administrative Law Judge In Charge.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
New Orleans, La., April 16, 1980.

Mr. PHILIP T. BROWN,
Chief Administrative Law Judge, Office of Hearings and Appeals, U.S. Social Security Administration, Arlington, Va.

DEAR MR. BROWN: I have reviewed correspondence from Administrative Law Judge Carl Sarett to you obtained by Administrative Law Judge J. Charles Collins, Jr., under the Freedom of Information Act.

Pursuant to the said Act, I am hereby formally requesting from you all copies of Judge Sarett's correspondence with you relating in any way whatsoever to me, particularly his report of January 31, 1978. I am also requesting the date that these reports commenced and the date they ceased, if, indeed, ever they did.

Sincerely,

GEORGE M. PONDER,
Administrative Law Judge.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
Washington, D.C., May 28, 1980.

Mr. GEORGE M. PONDER,
Administrative Law Judge, Office of Hearings and Appeals, SSA, New Orleans, La.

Dear Judge Ponder: This is in further response to your request pursuant to the Freedom of Information Act for "all copies of Judge Sarett's correspondence with [Chief ALJ Brown] relating in any way whatsoever to me, particularly his report of January 31, 1978." You also asked for "the date that these reports commenced and the date they ceased."

Enclosed are copies of records we have identified in response to your request. I am informed that there are no documents showing when the reports by Judge Sarett commenced or when they ended. Deletions have been made in the documents of information which we believe to be exempt from mandatory disclosure. We are referring your request to the Director, Office of Information, SSA, Baltimore, Maryland for a decision regarding the deleted material.

Sincerely yours,

DANIEL L. SCHULTZ,
Director, Office of Policy and Procedures.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
New Orleans, La., January 31, 1978.

To: Judge Philip Brown.
From: C. W. Sarett, ALJIC
Subject: Judges—BHA, N.O., La.

I have nothing of great significance to report for the month of January 1978 in regard to matters discussed at our meeting last November.

It should be stated, however, that there has been no substantial change in the pattern of reversal rates. One judge again has used an unusually high number of Medical Advisors. Another continues his practice of never using Vocational Experts.

CARL W. SARETT.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
SOCIAL SECURITY ADMINISTRATION,
New Orleans, La., February 10, 1982.

Mr. LOUIS B. HAYS,
Associate Commissioner,
Office of Hearings and Appeals,
Social Security Administration.

DEAR MR. HAYS: I have been given reason to believe that on February 25, 1980 a certain Burton Berkley, an employee of the Social Security Administration, addressed a memorandum to Andrew J. Young, your predecessor in office, containing a derogatory and libelous reference to me.

This memorandum has reference to certain litigation know as *Weaver* v. *Califano,* U.S. District Court, N. Dist. Ga., Atlanta Div., C-1437-A. Under the Freedom of Information Act, 5 U.S.C. 552 et seq., please furnish me with a copy of this memorandum.

Sincerely,

J. CHARLES COLLINS, Jr.,
Administrative Law Judge.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
SOCIAL SECURITY ADMINISTRATION,
Washington, D.C., February 18, 1982.

Mr. J. CHARLES COLLINS, Jr.,
Administrative Law Judge,
Office of Hearings and Appeals, SSA,
New Orleans, La.

DEAR JUDGE COLLINS: This is in response to your letter of February 10, 1982, in which you request, pursuant to the Freedom of Information Act, a copy of "a memorandum [dated February 25, 1980] to Andrew J. Young . . . containing a . . . reference to me" and concerning the case of *Weaver* v. *Califano.* Your request has been referred to me because of my responsibilities under the Freedom of Information Act.

I reviewed the memorandum and have concluded that it contains information which I believe may be withheld under the Freedom of Information Act. However, only the Director, Office of Information, can deny access to records of the Social Security Administration. Therefore, I am referring your request to that office in Baltimore, Maryland, for a decision on disclosure of the memorandum.

I note that your request was on Department of Health & Human Services stationery and you used a franked envelope. This is to remind you that employees of Federal agencies making requests under the Freedom of Information Act are acting as members of the public and not in any official capacity; thus use of official stationery and franked envelopes is inappropriate.

Sincerely yours,

P. J. KURAPKA
Director, Division of Appeals Procedures, Office of Policy and Procedures.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
SOCIAL SECURITY ADMINISTRATION,
Baltimore, Md., March 1982.

Mr. J. CHARLES COLLINS, Jr.,
Administrative Law Judge,
Office of Hearings and Appeals, SSA,
New Orleans, La.

DEAR JUDGE COLLINS: I am responding to your letter of February 10, 1982 to Mr. Louis B. Hays because of my responsibilities under the Freedom of Information Act.

After carefully reviewing the memorandum dated February 25, 1980 addressed to Andrew J. Young, which you are requesting, I have decided that it is exempt from disclosure under 5 U.S.C. 552(b)(5) of the Freedom of Information Act. The Freedom of Information Act exempts from disclosure ". . . inter-agency and intra-agency memoranda or letters which would not be available by law to a party other than an agency in litigation with the agency. . . ". In this regard the regulations of the Department of Health and Human Services provide that intra-agency and inter-agency communications are not available ". . . to the extent they reflect the views and judgment of the writer or other individual" (45 CFR 5.73). The memorandum in question expresses the views and opinions of the writer and therefore disclosure is not required.

If you disagree with this decision, you may request a review. Any appeal should be mailed within 30 days of receipt of this letter to Mr. Paul B. Simmons, Deputy Commissioner, 6401 Security Boulevard, Baltimore, Maryland 21235. Please mark the envelope "Freedom of Information Appeal."

Sincerely,

GILBERT C. FISHER,
Director, Office of Information.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
OFFICE OF HEARINGS AND APPEALS,
February 25, 1980.

To: OCALJ, AC, OAO, OPP, OA.

For your review. Item has been added to agenda for 2/26 Executive Staff Meeting.

B. HASKINS,
Executive Secretary.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE,
SOCIAL SECURITY ADMINISTRATION,
February 25, 1980.

To: Andrew J. Young, Associate Commissioner.
From: Burton Berkley, Special Counsel.
Subject: Proposed Settlement of the Weaver Case—Information.

PURPOSE

To inform the Associate Commissioner of the executive staff members' opinions regarding the proposed settlement.

RECOMMENDED USES OF INFORMATION

This information is being furnished to assist the Associate Commissioner in determining the extent to which we are willing to meet the terms of plaintiff's proposed settlement and in deciding what our response to the proposal should include.

FACTS

A meeting was held which was attended by the following executive staff members in addition to myself: Phil Brown; Irv Friedenberg; Ed Semans; Dan Schultz; and Jack Camilleri. All had reviewed the settlement proposal and were generally unenthusiastic about its terms.

Phil Brown observed that the very fact that we would agree to settle on plaintiffs' terms assumes that we are wrong and that we did engage in improper conduct. Dan Schultz believes that the settlement challenges the Secretary's authority and the legitimacy of management's right to monitor ALJ performance. He questioned whether OHA has the authority to agree to the terms of the settlement since it would, to some extent, restrict the Secretary or her successor in instituting future management initiatives intended to improve performance. I pointed out that we may end up with even more restrictive conditions if the court finds against us. Dan believes we should take that risk.

I informed the staff members that I do not believe plaintiffs' attorneys will agree to substantial modification of the proposed settlement. They have given up as much as they will give up. They believe that if reversal rates are available to reviewing authority or administrative supervisors, this will result in the possibility or appearance of pressure to conform to some sort of norm for reversal rates. I had explained to plaintiff's attorneys that OHA only uses reversal rates as an indicator of possible high defect rates, and that we had never threatened or counselled ALJs regarding reversal rates. The only counselling which had been or is done was and is based on specific defects in specific cases. They still believe however, that the knowledge of the availability of reversal rates to the Appeals Council members and Regional Chief ALJs possibly influences that ALJ corps in their decisional process.

Item (e), as it pertains to dissemination of reversal rates, caused a great deal of concern. Phil Brown is opposed to any settlement which would prohibit the RCALJs from obtaining copies of such data. He regards the RCALJs as the principal management officials in the regions. To prohibit them from receiving the reversal rates would deprive them of valuable information and be demeaning. Irv Friedenberg is willing to have the Appeals Council, including himself, excluded from distribution of reversal rate data. He does not believe this information is necessary for the Council to perform its primary task of reviewing Social Security claims. Dan Schultz does not believe Irv should bind future Appeals Council members from receiving this data. He further pointed out that reversal rate data is available to anyone who makes a request under the Freedom of Information Act. Thus, if a RCALJ, Appeals Council member or anyone else wanted this information, we would be required to furnish it under FOIA. Dan also pointed out that inasmuch as ranked reversal rate listings are retrievable from the computerized data system, we are required to furnish this information, upon demand and payment of costs, under FOIA. Also Congress sometimes requests this information. Item (f) would have to be revised to reflect these exceptions.

All of the participants were opposed to item (i). I explained that I had informed plaintiffs' attorneys this item was totally unacceptable because it would preclude the Appeals Council from reviewing a case on its own motion. They told me such was not their intention and they are amenable to modifying the language. I suggested that we redraft this item so it will be acceptable to us but the other executive staff members did not agree. They believe the item should be stricken in its entirety or plaintiffs' attorneys should be required to submit alternative language. I am opposed to this. I believe it makes us look as though we are playing games. I still favor redrafting the item with language acceptable to us, and I have done so in my suggested draft.

Dan suggested that we agree to split the cost for deposition and other court costs rather than pay the entire amount, otherwise it would appear we are conceding the whole case. Ed Semans said we had better determine the status of the Weaver and Parker claims before we agree to establish the onset dates set forth in the settlement. There may be something in the record, such as work activity, which would preclude continuous payment. We have now been informed by Walter O'Brien of OAO that these claims could be paid.

There was general concern about the composition of any class which might be certified. Everyone agreed that we would have to know the number of cases involved before we take any action on this item.

I have spoken with Miles Eastwood, now the Assistant U.S. Attorney representing the government, on several occasions concerning the proposed settlement. Miles was formerly the Assistant Regional Attorney assigned to the case, so he is very familiar with all aspects of the matter. He believes that we have a good chance of prevailing if it goes before the court for decision but, in view of the remand in *Nash,* there will probably be a full trial. He also said that the plaintiffs' attorney will want to take more discovery including your depoistion and those of Phil Brown and Jim Mortenson, who went to Atlanta with me. He thinks that it could easily take 4–5 years before the litigation, including appeals, is completed. If the case goes to trial we can anticipate that plaintiff will call as witnesses many of those same ALJs who have been in opposition to management who would have testified in the *Bono* case. We, of course, will counter by calling as witnesses many ALJs who support our position. Also, Miles said he would not hesitate to discredit ALJ Collins and ALJ Ponder by introducing evidence of the overt anti-Semitism they expressed towards ALJ Sarett and the former top OHA management. A trial will probably cause certain divisiveness and acrimony within the ALJ corps.

A further factor to be considered is the possibility of the adoption of the Bellmon Amendment. We certainly cannot bind ourselves in this litigation to act is such a way as to violate a statute.

I have attached, at Tab A, the settlement proposal submitted by plaintiff's attorneys. At Tab B, I have attached a redraft along the lines suggested by the executive staff. I do not believe this redraft would be accepted by the plaintiffs' attorneys.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
SOCIAL SECURITY ADMINISTRATION,
Washington, D.C., October 28, 1981.

Mr. J. CHARLES COLLINS, Jr.,
Administrative Law Judge,
Office of Hearings and Appeals,
New Orleans, La.

DEAR JUDGE COLLINS: This is in response to your request for "a copy of the names of all [administrative] law judges and hearing offices who have been sent instructions to forward their files to the . . . Office of Appraisal . . . ."

Your request was referred to me for reply because of my responsibilities under the Freedom of Information Act. Copies of the requested information are enclosed.

Sincerely yours,

P. J. KURAPKA,
Director, Division of Appeals Procedures,
Office of Policy and Procedures.

ONGOING BELLMON REVIEW

TARGETED HEARING OFFICES

Harrisburg, Pa.; Jenkintown, Pa.; Wilkes-Barre, Pa.; Roanoke, Va.; Billings, Mont.; Fargo, N. Dak.; Spokane, Wash.

TARGETED ALJ'S

Region I: Michael J. John, Boston, Mass.; Clayton A. Dietrich, Hartford, Conn.

Region II: Rafael Buono-Petrilli, Bayamon, P.R.; Jose J. Santiago,[1] Hato Rey, P.R.

Region III: Joseph E. Hodgson, Paul R. Stone, Charleston, W. Va.; David E. O'Neil, Huntington, W. Va.; David J. Kozma, Milton P. Shore, Pittsburgh, Pa.

Region IV: Frank B. Borowiec, Alfred A. Quillian, Doraville, Ga.; James G. Henry, Ft. Lauderdale, Fla.; Corwin G. Muse, Jr., Jackson, Miss.;

Region V: John T. Kelly, Cincinnati, Ohio; Harry E. Pickering, Cleveland, Ohio; Robert C. Walsman, Indianapolis, Ind.; James A. Kempker, Milwaukee, Wis.

Region VI: F. Philip Falvey, John F. Loehr, Albuquerque, N. Mex.; Joseph C. Collins, Jr., Thomas J. D'Aquila, New Orleans, La.

Region VII: Richard L. Jandt,[1] Kansas City, Mo.

Region IX: Barry M. Wesker,[1] Pasadena, Calif., Morris H. Kross, Phoenix, Ariz.; James J. Lawwill,[1] James S. Higgins, Nicholas G. Stucky, Sacramento, Calif.; Irving Shore, San Francisco, Calif.; Edward Schiff,[1] David C. Linehan, Santa Barbara, Calif.

Region X: Robert C. Wetherholt,[1] Gordon M. Callow, Raymond H. Warns, Jack Heller, Seattle, Wash.

ALJ'S INVOLVED IN ONGOING BELLMON REVIEW

Frank B. Borowiec, Rafael Buono-Petrilli, Gordon M. Callow, Joseph C. Collins, Jr., Thomas J. D'Aquila, Clayton A. Dietrich, Jack Heller, James G. Henry, James S. Higgins, Joseph E. Hodgson, Richard L. Jandt, Michael J. John, John T. Kelly, James A. Kempker, David J. Kozma, Morris H. Kross.

James J. Lawwill,[1] David C. Linehan, John F. Loehr, Corwin G. Muse, Jr., David E. O'Neil, Harry E. Pickering, Alfred A. Quillian, Jose J. Santaigo,[1] Edward Schiff,[1] Irving Shore, Milton P. Shore, Paul R. Stone, Nicholas G. Stucky, Robert C. Walsman, Raymond H. Warns, Barry M. Wesker,[1] Robert C. Wetherholt.[1]

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[1] ALJIC.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., April 7, 1982.

Hon. DAN ROSTENKOWSKI,
Chairman,
House Ways and Means Committee,
Washington, D.C.

DEAR DAN: For the consideration of your Committee, enclosed is correspondence I have received from Mr. John E. Davenport of Nashville, N.C., regarding H.R. 5700, the Disability Admendments of 1982.

With thanks and kindest personal regards, I am

Sincerely,

L. H. FOUNTAIN.

NASHVILLE, N.C., *March 31, 1982.*

Congressman L. H. FOUNTAIN,
Rayburn Building,
Washington, D.C.

DEAR L. H.: Thank you for your letter of March 15 enclosing Congressman Pickle's letter to you and the copy of the March 3, 1982 Congressional Record. On Monday, I called Walter. I also called the Committee Counsel and Mr. Pickle's Administrative Assistant.

On basis of my review of the proposals, I wish to give you the benefit of my observations. The first section of the bill related to disability termination appears to be a good idea.

The second section of the bill appears to me to be a great disservice to the workers of the nation and, unless there are substantial modifications, the defects in this section raise a question in my mind of whether the entire bill should be defeated. It has merit in strengthening the reconsideration process, but it does grave harm to the claimant's right to present evidence. The bill would cut off evidence at this level. I would estimate that 95 percent or more of the claimants have no attorney at this level. They are, by vast majority, uneducated and untrained in the legal process. Their doctors, by vast majortiy, probably 90 percent, do not know the "lingo" of the bureaucrat and do not know the regulations. For this reason the claimant does not get the right to a hearing at the state level.

Since this is true, a claimant is not likely to have his evidence at this level. No amount of telling them to get an attorney will suffice. From my observation of the N.C. State Office (operated by an independent state agency, apparently judged on its claims denial ratio), staffed in large part by foreign doctors, no claimant is likely to get a fair hearing, or to be able to understand his rights.

I agree some, but very few, may hold back evidence at this level. The vast majority know, or at least strongly feel that they are disabled. They do not know the medical reason or technical terms. They are often unable to employ doctors or attorneys to help pursue their claim.

Even the most educated of them, doctors and college graduates, feel that they will get a fair shake. My observation is that this simply does not happen.

There is no reason to believe that the proposed amendments will assure that the State office will obtain medical examinations, and that the claimants will have attorneys at this stage of the proceeding. A complete physical workup and examination by a specialist in the field is absolutely essential to assure that claimant's get a fair hearing and that all of the facts in their case are presented. Further, there is no assurance that a claimant or an attorney will be able to afford to go to the hospital to interview a claimant and get the full details of his ability to perform in accordance with the standards set out in the regulation. The function of the State office is to review written records of others, which are not in detail question and answer form, and without seeing the patients, about 75 percent of the claims are denied, if the Rocky Mount office is correct in its estimate. More often than not this is done by the reviewing medical personnel overruling the treating physicians.

The high appeal rate in the reconsideration process is a direct result of the increase of denials for the State office. I have no proof, but I am inclined to believe the State office is getting direction from the National Administration to turn down more and more cases, or else are writing up the State offices on the percentage of cases that they approve. When you get denials at the reconsideration level, the immediate effect is an appeal, especially if the claimant gets an attorney who talks with the treating physician and finds out that the claimant is truly likely to be classified as disabled.

A portion of the explanation of the bill says that the claimant would have the right to provide additional documentation on the same impairment. How is a lay claimant ever going to know what is wrong with him? He just knows the subjective feelings not the medical terms. If you are relying strictly on his statement or lay terms, you could exclude a large portion of the case.

I will give you several examples. I represent an indigent black claimant who was originally fond to be disabled. His claim was reviewed and he was denied benefits. He has been through two hearings. He did not have the funds to attend the reconsideration level, or to appear at the appeals level or to obtain doctors. The only way he ever got help was when he came to me and I directed him to doctors that I felt could prove his disability. His disability was obvious in looking at the record, although not stated in the exact terms of the Social Security regulation.

I represent another claimant who is a college graduate who has disabilities which appear to fall clearly within the regulations. Treatment for the first disability gave rise to discovery of a second disability at a later stage of the hearing. The two are medically related, in my opinion. The claimant should be able to prove them at reconsideration level.

The extension of a due process hearing requirement would not be any protection to a claimant, unless it can be assured that he has knowingly waived counsel, after talking with an attorney, and having his signature witness by an attorney.

The State Agency level is more or less a factory where written records are read. I do not believe that there is anything that Congress can do to change this as a fact. I realize that this puts some burden on the Administrative Law Judges, but rather than destroy the kitchen maybe you had better increase the size of the kitchen so they can take care of the claims that are presented and increase the number of Administrative Law Judges in a sufficient amount to handle the claim and make the State Agency responsive in assuring medical examinations during their process would relieve this burden.

An increase in the period of appeal would not be satisfactory unless there is added to the period of appeal a right to ask the State Agency to reconsider and hear new evidence prior to appeal and extend the period of time for appeal. There certainly should be provisions allowing time for the claimant or his attorney to obtain any evidence that they feel necessary before final reconsideration decision is made if you are going to cut off the evidence at this point.

On Friday, I took a half a day off from my office to talk with Social Security Officials. They tend to agree with my position. The ones I talked with feel that this section of the bill reverts to earlier procedures which proved ineffective.

One gets the feeling that the intent is to deny disability so as to make more funds available to use to soothe the more effective pressure groups, the retirees. The wage earner who has paid into the system deserves more protection not less. This is especially true since Supplemental Security Income disability is judged on the same basis. Congress, when it transferred disability determination on a welfare level to the social security program, placed the disabled in a severely deprived position. It also transferred a general fund obligation to the system which should have been left in the Social Services program. It was just another Nixon plan that did not perform as it was pictured.

The section of the bill relating to uniformity of decision making has some merit. However, the idea of continuing education for the people claimants are referred to for examination, is desirable. However, even more desirable would be a provision that the claimant could go to an expert of his choice.

There appears to be an aura that specialists employed by the Social Security Administration feel that they must find some reason for denying disability rather than finding out what the true condition of the claimant is.

In every case where I have written a doctor who has provided services to the Social Security Administration, by virtue of Social Security Administration rules, even with the claimant's authorization to release medical information, the doctors will refuse to provide it.

Certainly, there should be no such procedure unless the claimant's attorney has the right to cross-examine the examining physician at any level of hearing whether it be reconsideration, and it should be done in person.

As to the Social Security court, that provision, in my opinion, has some merit. However, care must be taken that these courts are composed of people totally independent of the Social Security Administration. Otherwise, there will be pressure for the court to conform to the Social Security Administration's ideas. There should be provisions for appeals into the general court system, whether it be district court or some higher level.

I again appreciate your hearing me out on this legislation. I realize the burdens imposed upon you as a lawmaker. I have served in the General Assembly myself. However, the provisions which I relate to in Section 2, in my opinion, are so bad as to make the entire bill objectionable.

Yours truly,

JOHN E. DAVENPORT,
Attorney at Law.

STATEMENT OF DISABILITY ADVOCATES, BOSTON, MASS.

Mr. Chairman and members of the Subcommittee on Social Security of the House Ways and Means Committee, Disability Advocates appreciates this opportunity to present testimony on legislation now pending before the subcommittee and soon to be marked-up.

Disability Advocates monitors legislation of prime interest to persons with disabilities throughout this Nation. Throughout the past years we have worked together with members of this subcommittee on issues of mutual concern on a non-partisan basis. We are grateful for the support we have received and have willingly given our assistance when possible.

My name is Peter Loeb and I am executive director of Disability Advocates.

Pending legislation includes the "Disability Amendments of 1982", H.R. 5700. We shall comment on this legislation after having put it in perspective.

Disability Advocates well remembers the dispatch with which the Social Security Subcommittee responded last year when it and the House of Representatives acted to restore the minimum benefit. The subcommittee, and the relevant committee of the other body, recognized a situation which could lead to a national disaster. It did not permit itself to be mislead by a few individual case examples, nor did it accept a strictly case-by-case solution.

We supported you in this action at that time.

We are now before a combination of circumstances which requires legislative remedy.

We come before you at a time when our people are dying and suffering due to reviews on a massive scale carried out under the Disability Amendments of 1980.

The enormity of the problem as it exists was eloquently stated by Senator Howard Metzenbaum in the Congressional Record of February 9, 1982 (S651-652):

[From the Congressional Record, Feb. 9, 1982]

(By Mr. Metzenbaum, for himself, Mr. Moynihan, Mr. Eagleton, Mr. Inouye, and Mr. Bradley)

S. 2086. A bill to amend title II of the Social Security Act to provide for certain procedures to accompany reviews of continuing eligibility for disability insurance benefits; to the Committee on Finance.

CONTINUING DISABILITY INVESTIGATIONS IMPROVEMENT

Mr. METZENBAUM. Mr. President, information has come to my attention that the Social Security Administration (SSA) is using seriously flawed procedures in its investigation of the continuing eligibility of current recipients of social security disability benefits. As a result, needed benefits are being denied to many truly disabled persons who have no alternative source of income.

Today, Senators Moynihan, Eagleton, Inouye, Bradley and myself are introducing a bill to correct the procedural inequities that we have found in the present system. While I agree that our social security system can ill afford to carry persons on its rolls who are no longer disabled, we cannot allow our cost-saving initiatives to become so overzealous that we harm those very persons who are most in need of Government assistance and protection.

Starting in March 1981, SSA, at the request of the administration, has engaged in a massive, accelerated review of title II disability recipients. Nationwide, State agencies are receiving over 35,000 cases for review each month and that number is expected to double later this year. The offices are severely understaffed, the backlog of cases is enormous, and there is tremendous pressure to move these cases quickly. SSA has informed the State examiners that they will closely scrutinize cases in which a decision is made to continue benefits, but there is no review of decisions to terminate benefits. As a result of this not too subtle message to decrease the disability rolls, some egregious errors are being made.

Agency personnel have informed my staff that very often the agency does not even request a medical report from the recipient's treating physician, particularly if that person is receiving care in a clinic setting. Even where medical evidence is requested, the agency is allegedly making its decisions to cease benefits prior to waiting a reasonable length of time for receipt of such a report or without reviewing those reports received.

In addition, serious allegations have been made concerning the quality and adequacy of the medical examinations conducted by the independent medical examiners under contract with the State agency. There are too many disturbingly similar stories of hasty 5-minutes interviews with indifferent doctors to believe that these are just isolated incidents. As a result of these ill-advised procedures, the State agency in Ohio is currently ceasing benefits in 47 percent of the cases it reviews while the termination rate nationwide is 45.1 percent. However, in Cleveland, the administrative law judges are reversing at least 50 percent of these initial State agency decisions when the cases finally reach them on appeal. In other States I understand that the error rate is even higher. This incredible reversal rate means that about 25 percent of the disability recipients being removed from the rolls by the State agencies are actually entitled to continued benefits.

The consequences of an erroneous decision by the State agency are severe. Despite a request for a hearing on this initial determination that a person's disability has ceased, benefits are terminated pending the hearing decision. The waiting period for such a decision can be as long as 1 year. When benefits are restored, as they are in at least 50 percent of the cases, it may be too late for those persons with no other sources of income.

My staff have been contacted by desperately ill persons who are being forced to sell their homes and resort to other serious irreversible measures while awaiting this restoration of benefits. Lives are being destroyed, literally, as a result of this process. Several recent suicides and suicide attempts have been attributed to the loss of social security disability benefits.

In one case brought to the attention of my office, Calvin J. Crick, a 55-year-old man who had been on total disability since 1975 when he suffered a massive heart attack, received a notice that his benefits were being terminated because he was no longer disabled. Despite the report of his own physician of 12 years that a series of four heart attacks had left Mr. Crick permanently disabled and unable to resume working and despite previous test results to this effect, the State agency insisted that they would need current laboratory findings. Mr. Crick agreed to undergo a heart catheterization to prove his disability despite the warning of his physician that the operation could be life threatening. Mr. Crick felt he had no choice but to take the risk because he had to support a wife and two children. When one of my staff insisted that a medical consultant as SSA in Baltimore review this case, it was found that Mr. Crick's case file already contained more than sufficient evidence to prove his disability. While Mr. Crick was saved from a life-threatening operation by the last-minute intervention of this office, how many other lives are seriously damaged because no one has intervened on their behalf?

In another Ohio case, a 59-year-old woman had been receiving disability benefits because of a heart condition and progressively deteriorating arthritis. She had worked for 27 years as a dental technician before suffering a heart attact. After several unsuccessful attempts to continue working, she finally was forced to go on disability. Last October, the State agency, ignoring the report of her treating physician, terminated her benefits based on the report of a State-paid doctor who had spoken to her for only a few minutes and who had not even conducted a physical examination of her condition. This woman's husband in 76 years old and he receives a small pension, but their income was cut in half with the loss of her disability benefits.

These and countless other similar examples have led us to the conclusion that a legislative change is necessary. My bill simply requires SSA and the State agencies to adopt fairer procedures in their review. It requires SSA to give adequate notice to recipients whose cases have been chosen for investigation in order to give them sufficient time to make doctor appointments, undergo necessary tests and examinations, and obtain medical reports. The notice will inform recipients that they should obtain a report of a recent medical examination of their disability by a provider of medical services of their choice and that such report will be used in determining their continued eligibility for benefits. It require the State agency to request such a report and to wait 30 days after their request for receipt of the report prior to making any determiniation as to whether the recipient's disability has ceased.

In addition, my bill would provide for a continuation of benefits in those cases where there is a substantial difference of medical opinion as to the recipient's disabling condition between the recipient's own treating physician and the consultative physician who was chosen by SSA or the State agency. Benefits would continue pending a hearing decision by the administrative law judge. Benefits would also continue during the appeals process for those recipients who could prove substantial dependence upon such benefits. This would only partially parallel the right to continued benefits which SSI disability recipients have under current law. Finally, in cases where benefits were continued pursuant to the above requirement, no overpayment could be recovered from recipients whose income did not exceed 150 percent of the poverty line if the final appeals decision was to cease benefits.

Time is of the essence in bringing about these needed procedural changes. Congress must take action to prevent further tragedies from occurring. We must not let our search for fraud and abuse result in harm to truly disabled persons who have worked and earned these benefits which they currently receive.

[RESUMPTION OF STATEMENT OF DISABILITY ADVOCATES, BOSTON, MASS.]

Another Statement of the Current Situation has made by Chairman Claude Pepper, Chairman of the Committee on Aging, in a recent letter to us. We include this letter for the record.

We are unable to provide an exhaustive analysis. We are sure that many of you have heard from your constituents on the matter.

We do wish to call the attention of members of this subcommittee to material from the front page of the Des Moines Register of February 9, 1982.

We wish to be clear that we are not responsible for any of the data presented, have not encouraged it and have no files outside of what is part of the public record. Our function is legislative.

The members of the Social Security Subcommittee are probably already aware of proposals, as part of the fiscal year 1983 budget, to alter eligibility rules thereby eliminating payments to an additional 115,000 individuals by classifying them as not permanently disabled. See: "Major Themes and Additional Budget Details", p. 62.

We look to the Social Security Subcommittee to eliminate relevant portions of the ammedments of 1980 which provide authority for the reviews.

SUPPLEMENTAL SECURITY INCOME—DEPARTMENT OF HEALTH AND HUMAN SERVICES

[Dollars in millions]

Funding	1981	1982	1983	1984	1985	1986	1987
Current services:							
Budget Authority	7,227	7,878	[1] 9,177	8,330	9,330	9,826	10,296
Outlays	7,191	8,000	[1] 9,188	8,268	9,326	9,823	10,292
Reagan Budget:							
Budget Authority	7,227	7,777	[1] 8,891	7,781	8,622	8,912	9,196
Outlays	7,191	7.900	[1] 8,903	7,779	8,618	8,909	9.192
Proposed Savings:							
Budget Authority		101	286	489	708	914	1,100
Outlays		100	286	489	708	914	1,100

[1] Since the first day of the first month of fiscal 1984 falls on a weekend, the first benefit check for 1984 is paid on the last weekday of 1983 thus making 1983 a 13 rather than 12 benefit month year.

PROGRAM DESCRIPTION

Supplemental Security Income (SSI) provides cash assistance to low-income individuals who are aged, blind or disabled. The current (1982) maximum monthly payments and income guarantees are $264.70 for an eligible individual and $397 for an eligible couple. These amounts are indexed annually for increases in the cost-of-living. Approximately 1.5 million aged persons and 2.1 million blind or disabled persons receive Federal SSI benefits. Another 500,000 persons receive State SSI supplementation payments only. Benefit checks are usually issued the first of each month.

PROPOSED CHANGE

The Administration proposes to:

Prorate the first month's SSI benefit from the date of application or date of eligibility (in the case of aged persons).

Restrict the definition of permanent disability to a prognosis of at least 24 months of disability.

Ensure that the definition of disability is based on a preponderance of medical rather than other factors.

For new beneficiaries no longer disregard the first $20 of income in setting benefit levels.

Recover overpayments to individuals from available Social Security benefits.

Continue to phase out transitional hold harmless payments.

RATIONALE

Under current law, all new recipients have been paid a full month's benefit regardless of the day of the month on which they file or, in the case of aged applicants, the day they become eligible for assistance (i.e., turn age 65). Consequently, most individuals who apply for SSI receive benefits for periods of time before they applied or were eligible. Prorating the first month's benefits based upon date of application (or eligibility) would base an applicant's benefits more fairly on the appropriate period.

Under current law, the monthly guarantee and actual payments are rounded to the next higher 10 cents in the computation process. Over time, however this rounding procedure has had a compounding effect that results in slightly higher benefit payments. Rounding the SSI guarantee and payment amounts to the next lower dollar would eliminate the modest overcompensation that results from the current higher rounding procedure.

The SSI definition of permanent disability includes a requirement that an individual's impairment must be expected to result in death or continue for not less than 12 months. Restricting permanent disability to nonemployable individuals with a prognosis of at least 24 months of disability would assure that temporary disabling impairments would not be a basis to qualify for benefits. The 24 month duration requirement is more consistent with the concept of *permanent* disability.

Individuals are considered disabled under SSI if their medically determined impairment is of such severity that they are not only unable to do their previous work, but cannot, because of education or work experience, engage in substantial gainful employment. Ensuring the definition of disability is based on a preponderance of medical factors would eliminate a problem under present law in utilizing vocational and other subjective nonmedical factors which make consistent disability determination decisions difficult. Relying on medical factors would produce more objective and consistent determinations and fewer appeals.

Under current law, $20 per month of an individual's income is disregarded in determining SSI eligibility and amount of benefits. Since the disregarded amount is fixed, it is of decreasing significance in real dollars. It also can result in differential treatment of recipients. Some people in similar circumstances get the maximum SSI payment of $264 and others having combined SSI and other income get $20 more a month than the maximum SSI payment. The proposed change would apply a uniform standard to newly eligible persons.

The Social Security Administration has been unable to recover more than forty percent of SSI overpayments because many of the overpaid individuals are no longer in the SSI program. Half of the former beneficiaries receive Social Security retirement and disability benefits. The proposed change would allow Social Security Administration to recover SSI overpayments from these no longer needy individuals.

EFFECTS OF PROPOSED CHANGE

Rounding benefit amounts and payment standards would have a minimal effect on individual benefits. Beneficiaries would have their monthly benefits reduced by an average of 50 cents.

Applying an established medical definition of disability would lower SSA's administrative costs and make disability determinations more consistent and objective.

This proposal would exclude payments to an estimated 115,000 individuals in 1983 who are not premanently disabled.

[From the Des Moines Register, Feb. 9, 1982]

4,000 IOWANS FACE DISABILITY—AID LOSS IN U.S. CRACKDOWN

(By William Petroski)

More than 4,000 Iowans are expected to have their Social Security disability benefits cut off during the next three years as part of a nationwide crackdown aimed at eliminating unqualified recipients.

Hundreds of Iowa residents already have been ruled ineligible for benefits. However, some attorneys contend that many people who are totally disabled are unjustly being dropped from the Social Security program or denied initial claims for assistance.

In one case, a 50-year-old Monroe County man who had psychiatric and medical problems suffered extreme anxiety when his benefits were terminated. He had a heart attack the day his case was appealed. The man, who had no prior history of heart problems, died 16 days later, on Dec 18, said his lawyer, Robert Sherman of Ottumwa.

Attorneys for the Legal Services Corp. of Iowa, which serves poor people, also point to cases such as that of Mary Greiner, 42, of Richland. Greiner is often bedridden because of severe medical problems. Her benefits were cut off after a disability examiner ruled she is capable of going to work.

$333 MONTHLY

Twenty-seven thousand Iowans receive a total of $9 million monthly in Social Security disability benefits. The average payout per person is $333 each month.

Bill Durst, district manager of Social Security in Des Moines, said 21,600 Iowans will have their disability cases examined by Sept. 30, 1984. An estimated 20 percent to 25 percent of those people will lose their benefits, said Ken Bischof, a spokesman for the Social Security regional office in Kansas City.

In Iowa, more than 4,000 people will lose assistance if the 20 percent termination figure is maintained.

About one-third of the people dropped from the Social Security program appeal the action, and about 64 percent of those win their appeals, according to Legal Service officials.

The move to review disability claims started last April, but the brunt of the re-evaluations began in January. Bischof said cases being reviewed currently are those that will most likely result in a cutoff of benefits.

Of 1,600 Iowans whose cases have been re-examined since October, 40 percent, or more than 600 people, have been disqualified for benefits. Many cases are being appealed.

The review process was mandated by Congress in 1980, said Price Farson, assistant director of the Disability Determination Service, which operates as part of the Iowa Department of Public Instruction. Congress also has established stricter standards for individuals to qualify for disability benefits, he said.

INELIGIBLE

A study by the federal General Accounting Office supports the congressional action. GAO investigators said the government was losing more than $2 billion annually to ineligible disability recipients.

Federal law states that all recipients must be totally disabled and unable to work for at least one year. The 80 percent who have physical or mental problems that may show improvement must be re-evaluated every three years. The remaining 20 percent, such as quadriplegics and the blind must have their cases reexamined every seven years.

In criticizing the disability determinations, Legal Service attorneys point out that an extraordinarily high percentage—64 percent—of the cutoffs are being reversed in cases that are appealed to administrative law judges.

An estimated 30 percent to 35 percent of people who are terminated from benefits file appeals, but many people don't appeal because they are discouraged or don't know better, said legal aid lawyers.

"It appears that in some instances that evidence supporting the terminations is very weak, said Dennis Grosnenboom, managing attorney of the Legal Service office in Cedar Rapids.

"Some of the decisions don't make any sense at all," said Anne Hoffmaster, a Legal Service worker in Fort Dodge. "Some of the people terminated have even had their conditions deteriorate since they were originally put on disability benefits."

Noting the nation's economic problem, one lawyer questioned whether an employer would hire any disabled person who had lost disability benefits, particularly when so many healthy workers are jobless.

PAPER EVIDENCE

Defending the review process, Farson of the Disability Determination Service said that his staff, which includes physicians, must base its decision solely on paper evidence such as doctors' notes and clinical evaluations. His staff rarely sees the disability claimants.

In addition, the Social Security Administration says that in cases of disability cutoffs nationally, quality control studies have determined the disability examiners are accurate in 96 percent of the cases they review.

Social Security spokesman Bischof said many cases are reversed on appeal because administrative law judges have more freedom to interpret federal disability legislation and Social Security regulations. The judges also meet individuals in person, and they are permitted to consider how pain affects a claimant's performance.

In comparison, the disability examiners are not permitted to consider pain when making a determination of eligibility.

"We can see there is a difference" in decisions reached by judges and disability examiners, Bischof acknowledged. As a result, he said, Congress and the Social Security Administration are discussing an effort that would permit decisions to be based on similar guidelines.

APPEAL PENDING

The 60-year-old Monroe County man who died of a heart attack after his benefits were terminated was a recluse according to Iowa Department of Social Services records. Sherman, the man's Legal Service attorney, has declined to release the man's name because his appeal is pending before an administrative law judge.

Thenan had once been a railroad and brick worker but suffered from mental illness and chronic alcoholism and had problems with stomach ulcersarthritis and a bad back.

After the client was examined by a non-pschiatric doctor in Ottumwa, he was ruled ineligible for disability benefits. The man suffered extreme anxiety Sherman said, and suffered a heart attack on Dec. 2, the day of his appeal. He died Dec. 18 of a second heart attack.

"The problem was that his impairments were mental and they sent him to a medical doctor," Sherman said. "The doctor just gave him an exam and said, 'I think he can work.' "

"In my opinion, a hearing on this case was totally unnecessary and the anxiety he had may have caused his heart attack," Sherman said.

Farson of the Disability Determination Service said it is possible that Sherman's client was examined only by a medical doctor. However, the determination of the man's mental condition could have been based on notes submitted by the man's psychiatrist, Farson said.

"We ask all doctors to refrain from telling us whether the client is disabled," Farson added. "We make all decisions on whether they are eligible or not based on the clinical findings."

CANCER

In another case, Greiner of Richland, a small town in Keokuk County, suffers from cancer in her sinus cavities, which causes severe headaches. She also has staphylococcus infections, frequently suffers pneumonia, has had four ruptured spinal discs and has intestinal problems that require her to eat only strained food.

"The last two years I have been in the hospital more than I have been out," said Greiner. "There have been weeks that I am not able to get out of my house. There are lots of days I never even get out of my pajamas."

Greiner, who has been ill for about four years, began receiving Social Security disability checks in 1980. She said she received a letter from Social Security last fall notifying her that she could resume a work schedule effective Oct. 1. However, she was hospitalized from Sept. 24 until late October.

Greiner is attempting to have her eligibility for benefits reinstated, but her assistance checks have been stopped. Meanwhile, she is trying to determine how she can live without any income.

"I've talked to the bank about getting money to help me through, and my one sister will probably help me. It's rough, but somehow I'll get through. I've done it before," she said.

Apparently, the key reason why Greiner is no longer eligible for benefits is that she is not considered "totally disabled." Persons who are considered partially disabled are not qualified for Social Security assistance.

Farson emphasized that the amendments to Social Security laws passed by Congress have made eligibility requirements more strict.

"As a consequence, it makes it more difficult to be considered totally disabled for Social Security purposes," Farson said.

U.S. House of Representatives,
Select Committee on Aging,
Washington, D.C., February 4, 1982.

Mr. Peter Loeb,
Executive Director, Disability Advocates,
Boston, Mass.

Dear Mr. Loeb: Your letter regarding the Administration's efforts to reduce the Social Security Disability Insurance rolls was received and very much appreciated as it dealt with an issue of concern to millions of elderly and disabled Americans.

I am concerned that the Administration's effort to reduce the disability rolls has created fear and turmoil among the nation's four and one-half million Disability Insurance recipients. In a program so strictly administered that the number of new awards has shrunken steadily over each of the last five years, it is highly unlikely that this frantic purge of thousands of people from the rolls during the past few months will exclude the completely disabled.

In response to the Administration's zealous recertification process, Representative J. J. Pickle, Chairman of the Ways and Means Social Security Subcommittee, has scheduled hearings to investigate the validity of this recertification process. In addition, I will do everything in my power to ensure that the rights of Disability Insurance recipients are honored in accord with due process of law. Your taking the time to alert me to this matter was very much appreciated. You know that as Chairman of the Select Committee on Aging I will not stand idly by and allow short-term budgetary considerations to come before the welfare of the handicapped people of this country.

With kindest regards,

Very sincerely,

Claude Pepper, *Chairman.*

[From the Des Moines Register, Feb. 9, 1982]

WIDOW SEEKS ANSWERS TO HUSBAND'S DEATH

(By William Petroski)

Council Bluffs, Iowa.—The widow of Harold R. "Sonny" Holtz—who killed himself two months ago after he ws denied disability benefits—has a message for President Reagan as he visits Iowa today:

"He should really have a better understanding when people need help," says Deloris Holtz. "There are people who are getting things who don't deserve them. But there are people who deserve it and the door is getting shut in their face."

Sonny Holtz, a 45-year-old former truck driver and the father of four children, ages 10 to 19, died at 10:23 p.m. on Dec. 4 of a self-inflicted, .22-caliber gunshot wound in the right temple. His suicide came after nearly a year of attempts to obtain Social Security benefits. He was denied benefits even though he suffered from heart problems, high blood pressure, diabetes, and vision problems related to his diabetes.

Deloris Holtz says her husband killed himself because of his frustration with the Social Security Administration. Her story was confirmed by an aide to U.S. Representative Tom Harkin (Dem., Ia.) and a worker for the Legal Services Corp. of Iowa who handled Holtz's case.

As a result of Holtz's death, his family has begun receiving Social Security survivors' benefits. However, Holtz's original request for disability benefits still is being appealed to a Social Security council in Baltimore, Md.

Deloris Holtz, 41, says she is certain her husband committed suicide so that his family could receive "survivors" benefits. "Nobody would help him, so he figured at least someone would help us. He doesn't have to cry for help no more," she said.

Deloris Holtz, who works for the Kitty Clover potato chip company in nearby Omaha, Neb., was interviewed Sunday afternoon in the kitchen of the Holtz family's well-kept one-story home in a blue-collar neighborhood on the south end of Council Bluffs. She agreed to talk about her family's tragedy, saying she hopes the government will begin to act with compassion toward other families who suffer similar problems.

Harold Holtz, a hefty man who wore his hair in a crew cut, dropped out of school after the eight grade and had spent most of his working career as an over-the-road truck driver venturing throughout the United States for 21 years without ever having an accident.

HAD MANY FRIENDS

A lifelong resident of Council Bluffs, he had many friends and enjoyed visiting with people. "He never met a stranger," his wife recalled. He'd talk to people for a half hour and know their life history." Although Holtz liked to bowl, he spent most of his free time at home with his children, his widow recalled.

His problems began when he was forced to quit his most recent job—with G & I Trucking of Harlan—after his diabetes became more severe and he was required to start taking insulin in October 1980. U.S. Department of Transportation rules would not permit him to continue interstate driving while taking insulin.

Holtz then sought unemployment benefits and was referred to the state vocational rehabilitation office in Council Bluffs. But he first was required to undergo a physical examination, which revealed the blockage of three coronary arteries.

On Jan. 21, 1981, Holtz applied for Social Security disability benefits and Supplemental Security Income, and ws denied. In February 1981 he underwent a triple-bypass heart operation, which was aimed at alleviating the blockages.

"TREMENDOUS PAIN"

After the operation, doctors told Holtz he was fine, although it would be about six months before he could work again. But his wife said he was in "tremendous pain all the time."

He couldn't sleep. He'd walk the floor at night and the doctor would say "Well, its anxiety because he's out of work" and blah, blah, blah . . . Pass the buck.

"They'd change his medicine and do this and that and the doctor said 'Well, Harold, you could be in some pain, but everything shows that everything is coming out all right,' " Deloris Holtz said.

She questions whether her husband's surgery was successful. She says that before it was determined that he needed heart-bypass surgery, doctors downplayed severe chest pains he had experienced. It was only after he had undergone a heart catheterization test that doctors agreed he had heart disease, she said.

In April, Holtz filed an appeal of the Social Security Administration's denial of his requests for benefits. On Sept. 9, he appeared before an administrative law judge in Omaha, but his appeal was turned down.

The judge ruled that Holtz's ailments did not constitute a disability "as defined under the Social Security Act" and were "not severe enough" to prevent him from holding some kind of job.

TRANSFERABLE SKILLS

The judge agreed that Holtz suffered from heart disease, diabetes, eye problems, and anxiety. But he wrote that Holtz could perform sedentary work and that he had job skills that were transferable. The record did not state what job skills involved in truck driving could be used in other forms of work.

And although Holtz still suffered from what he described as severe pain, the judge said the pain was "not disabling in scope."

In questioning the administrative law judge's decision, a legal assistant for the Legal Services Corp. of Iowa has written in support of Holtz: "While there is evidence in the record that [Holtz] could not do his job, the administrative law judge presented no vocational expert or other qualified person who testified that he could, given his age, education and severity of disability, do any other job."

Despite his extreme pain, Holtz studied newspaper help-wanted columns each day and sought help from Job Service of Iowa, Deloris Holtz said. But she said he repeatedly was informed by employers that they could not risk hiring him because of his many health problems.

In November, after he changed doctors, Holtz was hospitalized again for a week. He was discharged so that he could have Thanksgiving dinner with his family.

INCREASINGLY DEPRESSED

Meanwhile, Holtz had become increasingly depressed and was taking medication for his anxiety. On Dec. 4, Holtz could stand the frustration no longer, and he ended his life. His death was ruled a suicide by the Pottawattamie County coroner's office.

Doris Davis, a paralegal who had worked on Holtz's case for Legal Services says she definitely believes Holtz's suicide was caused by the denial of his request for Social Security disability benefits.

"He was disabled and there wasn't anything else he could do. He felt people were telling him he could work, but he had pain and he couldn't. He began to feel he was in the way because he couldn't get benefits and couldn't work."

Barry Piatt, Harkin's press secretary in Washington, said Holtz did not directly threaten to commit suicide if he were denied benefits. But both Piatt and Davis said Holtz had made offhand remarks about taking his life.

"He was involved in a lengthy process and he was so frustrated with the process that he killed himself," Piatt said.

SOME CAN WORK

Asked to comment on the case, Price Farson, assistant director of the state Disability Determination Service, said it is possible that a person could be denied disability benefits despite having a heart ailment. Some heart patients, after an evaluation by a physician, are deemed able to do light work, he said.

"Here's the trouble with pain," Farson added. "How do you evaluate it? . . . I don't know how you can determine the pain unless there is some clinical evidence, and that is very difficult to evaluate. That's one problem we have with people with back problems."

Farson also emphasized that federal law requires that all recipients of disability benefits must be "totally disabled" and unable to work for at least one year.

MATTER OF PRINCIPLE

After Holtz's death, Harkin—who had telephoned Holtz at home twice and had intervened on his behalf with the Social Security Administration—contacted Deloris Holtz and asked her if she wanted to continue appealing her husband's denial of benefits. She agreed she still wanted to push the case as a matter of principle. If she wins the appeal she will be provided her husband's benefits retroactive.

But even if she wins the appeal it will be of little solace to Deloris Holtz and her children, who must spend the rest of their lives without their husband and father.

"It's hard. It really is," Deloris Holtz said sadly. "They say pick up the pieces and go on. But it's awful darn hard . . ."

[RESUMPTION OF STATEMENT OF DISABILITY ADVOCATES, BOSTON, MASS.]

We hope that the subcommittee passes no legislation which affects eligibliity determinations or which makes more difficult the right of the claimant to secure entitlements under law. Equally we oppose efforts to make such determinations in any way "discretionary."

The legislation under consideration does not repeal authority in existing law for reviews. Instead this legislation encourages these massive reviews.

The expression of sympathy for overworked administrative law judges and their case loads seems to us misplaced. These caseloads should be reduced but not by leaving a trail of death and extreme suffering.

Provisions authorizing such reviews should be repealed.

H.R. 5700 contains no provisions repealing said authority but rather expands on this authority. We find this unacceptable and urge members of the subcommittee of both parties to reconsider.

We have in previous communication to the chairman and to members of the committee opposed the use of POMS. It is not proper for executive manuals for determination of eligibility for benefits be decisive for all adjudication.

Such executive control of the adjudicative process renders it meaningless. Whatever the title, the adjudicator has no recourse but to follow the rulings of an executive branch. It is our hope that the courts or others in the adjudicative process will not have their hands bound in advance of a decision.

We urge that the part of the weaker, the beneficiary, be strengthened. In a so-called "strengthening" of the reconsideration process it is the hand of the Social Security Administration or the ALJ's which are strengthened at the expense of the rights of disabled individuals.

In defining pain, the subcommittee has eliminated pain as a relevant factor and has eliminated the importance of vocational effects, other factors as expressed by the person experiencing the disability. As this has already caused great grief, we oppose this proviso.

It is not the function of our social security system to provide medical school courses on disability. We hope that the medical schools accomplish this task.

The centerpiece of H.R. 5700 is the establishment of a social security court. We are well disposed toward this concept but do not wish to comment on it in detail. In the context of the present bill which lacks adequate repeal of authority for reviews under any amendments whatsoever and because the measure affects in a disadvantageous manner questions concerning eligibility under the disability insurance program, we cannot support H.R. 5700 at this time.

Many thanks. We look forward to the necessary repeals taken on a bi-partisan way within the Social Security Subcommittee.

Statement of Wilbert E. Fordyce, Seattle, Wash.

The following is submitted for the written record of the hearings on the "Disability Amendments of 1982", announced for March 16, 1982.

I am Wilbert E. Fordyce, Ph.D., Professor of Psychology, Department of Rehabilitation Medicine and the Pain Service, University of Washington School of Medicine, Seattle, Washington, 98195, Phone: (206) 543-8660.

This submission occurs in an individual capacity. My credentials to the matter are:

I am the principal developer of the use of behavioral methods in the evaluation and management of chronic pain. Those methods now make up a core part of virtually every pain treatment program in the United States, Canada, and Western Europe.

I authored the first and only text for use of these methods.

There are in the professional literature 47 research reports, chapters, or books authored or co-authored by me having to do with pain (its definition, measurement, evaluation, or management) or behavioral methods in health care delivery.

I am past president of the American Congress of Rehabilitation Medicine, and founding member of the International Association for the Study of Pain, the American Pain Society, and the Academy of Behavioral Medicine Research.

This statement addresses the following topical points:

Provisions to Provide More Uniformity of Decision Making:

(1) Federal definition of pain.

(2) Formation of an Advisory Council.

1. FEDERAL DEFINITION OF PAIN

The definition and determination of pain is crucial to the adjudication process. The proposed wording is excellent. The definition, with one minor addition, which I shall propose below, merits full support.

We now have data which support what has long been suspected; namely, that verbal reports of claimed impairment associated with reported pain, like the verbal reports of pain intensity, are subject to influence by a variety of factors unrelated to physical findings or body damage. As a consequence, the mere report of having functional or performance limitations, should not suffice to establish there is a disabling pain problem. Accordingly, it is proposed that the definition of pain proposed in the amendment be modified to read as follows: (Sec. 9(a) Section 223(d)(5): "An individual's statement as to pain or other symptoms, or of limitations in the performance of tasks or activities because of pain, shall not alone be conclusive evidence of disability as defined in this section; . . ."

Without this addition, might there not be some risk that patient or family reports of inability to engage in specified activities or to perform given amounts of some task, could be taken as indirect and therefore adequate evidence of pain?

A few additional comments in support of the proposed definition are in order. Anyone with even a modicum of experience in the evaluation and management of chronic pain knows full well that many people have been adjudicated as permanently disabled (total or partial disability) from pain when there are no medically documentable physical findings. The assumption has been made that this occurs because of ambiguity in the identification of the presence or absence of a pain problem; a flaw in the criteria for defining pain. That is correct. It is also true, however, that the assumption has been made that the adverse consequences of the award of disability status, even if legally in error are only that the person receives benefits to which he or she is not entitled at the expense of those who provide the funds through tax monies and contributions to disability benefit programs, and the further loss of contributions and taxes from the disabled person. There are additional adverse effects of these erroneous adjudications which have not received ample recognition.

We do not do a favor to a person when we assign him or her to disability status because of pain. Following injury and onset of pain and during healing time of the injury (a time which virtually never can last more than a few weeks: even a fractured bone heals within six weeks!!) the person's displays and communications of pain and suffering (known as "pain behaviors") influence those around the person. Their reactions in turn often promote a learning/conditioning effect which causes pain behaviors to persist beyond healing time. The pain behaviors are the same but they may now persist for different reasons. It is analogous to smoking. People begin to smoke for one set of reasons, but, if they persist for a few weeks, they will continue smoking for a different set of reasons: learning/conditioning. The behavior is the same but the reason it occurs is now different.

The principal flaw in the older and more traditional ways of defining pain is failure to recognize pain behaviors, like all other behavior, are sensitive to conditioning effects.

There are additional adverse consequences. Those around the suffering person tend to encourage limiting activity, resting, taking medications, etc. The result is reduced activity, which is almost inevitably followed by depression, a condition one finds in virtually every chronic pain patient. The depression, in turn, produces more suffering and more encouragement from others to guard oneself from over-doing—which leads to even more depression. It is a vicious cycle.

The problem is further worsened because the communication of suffering and reports of "pain" exposes the person to the risk of imprudent physician prescription of addicting analgesics, to physician prescribed but unnecessary and often harmful rest and over-protective behaviors, and even to unnecessary surgery.

Chronic pain problems rarely remain stable. They get better soon after healing time or they gradually worsen. Assignment to permanent disability status because of pain, when there is failure to recongnize the adverse effects of the actions of others on the pain problem, leads to more suffering and more disability.

Assignment of permanent disability status to soft tissue injury pain problems risks dooming the person to a gradually increasing level of suffering. If proper intervention occurs early enough, that is a quite unnecessary outcome. The proposed definition serves that end.

2. ESTABLISHMENT OF A PERMANENT ADVISORY COUNCIL

The proposed Council could serve many useful functions. I wish to make only three suggestions in regard to this matter. First, it should be recognized that the law is concerned with chronic disability and illness and the proper management of those requires a blending of Medical Science and Behavioral Science; which, incidentally, is not to be construed as traditional Psychiatry. They are quite different. Behavioral Science in health care, as exemplified in the field of Behavioral Medicine, is perhaps the most rapidly growing aspect of illness, health, and health care technology. The Council should reflect this fact by incorporating into its structure adequate representation from Behavioral Science. If it limits itself to traditional medicine, it limits itself to a mode of conceptualizing and managing chronic pain and disability which has demonstrably failed to resolve the problem.

The Council's composition should also recognize that rehabilitation is the major process by which people can be helped to get back into the mainstream. There should also be adequate representation from both medical and vocational rehabilitation.

Finally, I propose that the Council (or perhaps the authority should reside within the Social Security Administration) should be empowered to foster studies comparing alternative methods for restoring people presently on SSDI roles—whether from pain or for other reasons—to employment or reduced extent of disability, or reduced health care utilization in relation to their disabilities through properly sophisticated comprehensive rehabilitation.

DALLAS, Tex., *March 25, 1982.*

John J. Salmon,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. SALMON: I am an Administrative Law Judge with the Dallas Downtown Office of Hearings & Appeals. I wish to file this written statement for the printed record of the hearings on H.R. 5700, the disability amendments of 1982. My comments and proposals will be confined to the issues involving the reconsideration process.

First and foremost, any changes made in the reconsideration process by the United States Congress, can be expected to go astray when left to the tender mercy of the Social Security Administration for interpretation and implementation. The Social Security Administration in recent years has been pushing for uniformity in the adjudication of claims at all levels. The question is, does Congress really want the type of uniformity that Social Security Administration has in mind? The only way that uniformity can be achieved is to give the Commissioner authority to dictate to all levels of the decision-making process.

Uniformity will not be achieved if the Administrative Law Judges are required to use the same material that state agency adjudicators use in making their determination. It had been stated that the state agencies rely on the adjudicative standards of the program operations manual system (POMS), interim circulars, disability handbook and Lord knows what else, in making a determination. It is true that the Administrative Law Judges rely upon different criteria; namely, the Social Security Act, Court Law and regulations. Unless I am sadly mistaken, these are the only legal criteria for making a determination. As long as the state agencies award benefits in a prescribed percentage of cases, regardless of the criteria used to make a determination, the results have to be the same.

Congressman Pickle has stated, "Contrary to popular belief, the disability program is alive and working well financially. It is running surpluses which are being used to help pay retirement benefits under the larger retirement program. The percentage of workers on the disability rolls is the lowest in the history of the program."

The current Commissioner of Social Security and his predecessors over the past few years have apparently operated on the premise that the Trust Fund is going broke, the disability program included. Recently, under the doom theory, people are being denied benefits who not only meet the definition of disability but who meet the medical listings, a much more demanding standard. Since the recent big push began to cease benefits of claimants, I have seen some very strange reasons for cessation. A claimant who was originally found disabled because of a psychotic condition was referred to an orthopedic surgeon for a consultative physical examination. He was found to have the residual functional capacity for medium or heavy exertional work and his benefits were ceased despite the orthopedic surgeon's remark that, "this man sure acts funny." I don't think that using POMS can explain this situation. It does make one wonder about the state agency's claim that their determinations are 99.5 accurate.

It is well and good to discuss new approaches to the reconsideration level for it is recognized as being no more than a rubber stamp and a delay in the hearing process as presently constituted. However, there can be no change until the initial and reconsideration determinations are made on merit and not on the basis of a quota system. An alternative to the present reconsideration determination could be the lottery system.

Thank you for your consideration.

Respectfully,

HARRY T. HOLLAND,
Administrative Law Judge.

Department of Health and Human Services,
Social Security Administration,
Fort Smith, Ark., March 26, 1982.

Re H.R. 5700.

Hon. J. J. Pickle,
Chairman, Social Security Subcommittee, House Ways and Means Committee, House of Representatives, Washington, D.C.

Dear Mr. Pickle: We have thoroughly read H.R. 5700 and wish to make comments regarding this legislation. We are Administrative Law Judges with the Office of Hearings and Appeals, Social Security Administration, Fort Smith, Arkansas. We feel that we are in a position to make appropriate comments regarding this legislation since we are hearing cases for disability on a regular basis while serving as Administrative Law Judge. Please consider this letter as our joint statement for the record.

First, we believe the bill makes some erroneous conclusions regarding the disability process. As you know, the Congress enacted into law a requirement that the record in a disability case would close following the hearing before the Administrative Law Judge. This was done in the Disability Insurance Amendments of 1980. We believe this is the correct way to handle introduction of new evidence in a disability claim. Many times evidence will be provided at the hearing level which indicates a worsening of a claimant's condition, or a new impairment. The Administrative Law Judge is able to develop the record in light of the testimony and then he is allowed to make a decision regarding his findings. H.R. 5700 closes the record at the reconsideration level and precludes the Administrative Law Judge from considering new evidence at the hearing. H.R. 5700 also provides a hearing at the reconsideration level. There is no indication that a hearing will be conducted by a person at the reconsideration level who is protected by the Administrative Procedures Act. Without this, a hearing at the reconsideration level would be nothing more than perfunctory, and would be a waste of time for the claimant and/or his representative. Furthermore, we believe that without APA protection at the reconsideration level, the claimant might conclude that if his request for reconsideration is denied, there would be no reason to appear before the Administrative Law Judge, who is protected by the APA.

Our second objection to this legislation relates to the provision regarding remand provisions. Although there are times when a remand is appropriate, we are afraid that a claimant will see his case being shuffled back and forth between the different levels of adjudication within Social Security and, therefore, his case will take much longer for review and disposition, thus denying him due process.

Section 11 of H.R. 5700 deals with medical school courses and continuing education and disability. We believe that this section also should be made available to Administrative Law Judges who continually evaluate evidence and certainly need continued training in the area of medical disabilities. We would find it an effective tool for evaluation of disability cases.

Next, we wish to make comments regarding the establishment of the Social Security Court. We believe the concept of a Social Security Court is good. However, there is nothing in this section of your bill which provides that persons currently serving as Administrative Law Judges would be entitled to permanent appointments in light of their current appointments. We do note that Section f(1) provides that the Social Security Court is authorized to appoint, in accordance with Title V, certain employees to effectively execute the functions of the Court. We believe H.R. 5700 should specifically provide that current Administrative Law Judges are automatically appointed because we believe the Administration might use this legislation as a means to attempt to terminate Administrative Law Judges currently functioning and to choose only those with whom they find favor. We also note that the bill uses the term "commissioner" in Section (e)(3), whereas the proper term should be the current title, "Administrative Law Judge".

Section 13 of H.R. 5700 deals with attorney fees. We have never felt that the approving of attorney fees was in any way a problem. We believe that approving attorney fees keeps us currently in contact with members of the bar and with attorneys who represent people before us. We believe that attorneys who appear before us serve a useful function. That is, they help in the introduction of additional evidence and in further development of a claim before the Administrative Law Judge. We believe Section 13 will have its immediate effect in discouraging attorneys to represent claimants who have disability claims and we believe that without the aid of attorneys, the job of adjudicating cases becomes much more difficult. However, if the Subcommittee should choose, we believe that if you do not want attorney fees to be approved by the Administrative Law Judge, we suggest that any check for past-due benefits contain the names of both the claimant and attorney so that attorneys can receive their agreed upon fees. However, without this insurance to payment, we believe many attorneys will just simply refuse to take Social Security cases. In the practice of law, many large insurance companies always included the name of the attorney and the payee so that disposition could be made appropriately. We think this practice, as it relates to Social Security, would be an aid to attorneys and claimants alike.

H.R. 5700 provides that a claimant who has been ceased shall have the right to have his benefits continued through the reconsideration decision. Although we think this is meritorious, we believe that the claimant should have the right to have his benefits continued through the decision of the Administrative Law Judge since it has been our observation in the great majority of cessation cases that have been before us, they were erroneous cessations. There are some cases that have been properly terminated and we do not hesitate to reach this conclusion when the evidence clearly warrants it. However, in the last several months since the cessation cases have multiplied at the hearing level, in a great majority of cases we have heard and considered, benefits were continued.

We hope that our comments have been of some assistance to you and we look forward to reviewing the final bill as submitted to the Congress by the Subcommittee. We hope that the suggestions we have made herein will be worthy of your consideration.

Yours very truly,

JERRY THOMASSON,
Administrative Law Judge.
FRANCIS MAYHUE,
Administrative Law Judge.
DAVID T. HUBBARD,
Administrative Law Judge.

INTERNATIONAL REHABILITATION ASSOCIATES, INC.,
Wayne, Pa., March 22, 1982.

Hon. J. J. PICKLE,
Chairman, Subcommittee on Social Security, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: International Rehabilitation Associates, Inc. (IRA) supports Section 17 of H.R. 5700. IRA is the oldest and largest independent provider of insurance rehabilitation in the world. We are a wholly owned subsidiary of INA Corporation. Our home office is in Wayne, Pennsylvania. We have 79 other offices across this country. We also operate in Canada and Australia. Since 1970, we have served over 120,000 handicapped citizens. I am appending as Exhibit A information which tells more about insurance rehabilitation.

THE IMPACT OF SECTION 17

I will restrict my comments to Section 17 of H.R. 5700. We are pleased with the bill's approach to rehabilitation. It acknowledges that the shape of rehabilitation in 1982 is quite different than it was in 1972. Today there is a well-developed private for-profit sector composed of high quality practitioners. H.R. 5700 recognizes the private sector both as providers of on-going case service and as the subject of ten demonstation grants. We do wish that language of Section 17(d)(1)(D) were a little stronger. The apparent intent of that provision is that the private sector should participate in the program at least to some extent. Yet if a Commissioner of Social Security were to have a systematic bias against the private sector, we could be effectively blocked in our efforts to provide service to Social Security. That is our only concern. We support the provision instructing the Commissioner of Social Security to require reports on the operation of rehabilitation programs both public and private.

We have a particular interest in the ten demonstration grants. These grants will give the private sector the opportunity to prove its capabilities not only in the provision of direct client services but also in the disability determination process. We are aware of the proposal made by Ability Information System, Inc. We have an alternative approach to theirs.

THE IRA APPROACH TO DISABILITY DETERMINATIONS

IRA believes the Social Security Disability Insurance System in general is working, but that the system can and should be tightened. The goal should be to assure that every individual who is legally disabled receive benefits and that everyone who is not legally disabled not receive benefits. We believe further that it is in everyone's interest that the determination be made fairly, promptly, and with adequate protection of due process. We also believe the determination process must be cost-effective.

We believe the current system does not succeed in achieving all of these goals. In 1980, there were approximately one million claims including concurrent Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) claims. Of those claims, 670,000 individuals were denied at the initial claim level. Of those denials, 295,000 individuals requested reconsideration. Only 15 percent (or 45,000) of those requesting reconsideration were allowed at that level. Yet when 163,000 of those claimants denied at reconsideration requested a hearing, almost 60 percent (or 95,000) of their claims ultimately were awarded at the final stage. Even those statistics may not reflect the full problem. Some of the claimants denied benefits at either of the first two levels may have ceased efforts in discouragement rather than because they believed they were not deserving of benefits. And many of the denials appear to have been made because records were seriously deficient at least until the Hearings and Appeals level.

We believe there is a cost-effective solution. The disability determinations examiner is in a position directly analogous to the insurance claimsperson. The insurance industry has increasingly turned to organizations like IRA to perform sensitive and thorough information gathering. We believe face to face information collection from various combinations of treating physicians, employers, and in all cases the applicant, provides an adequate basis for prompt decision making if done by trained professionals. Such an evaluation can be performed at the original consideration level, at reconsideration, or at the hearings level. The reporting of this data is individually customized to meet the specific information requirements at the various stages of determination. The cumulative personal knowledge of a wide range of employers (combined with labor market statistics) and the specific knowledge of the claimant's component transferrable skills give the rehabilitation specialist practical and concrete knowledge about whether the claimant can actually perform jobs that exist in one or more regions of the country. IRA reports are provided in a prompt and comprehensive manner. In contrast to the current system there should be no delays, no need for repetitive evaluations, and most importantly no waste of dollars. Claimants should never be left with the feeling that their government has not cared enough to help them gather sufficient information for their claim to be promptly and fairly judged. IRA can help with this process. These same techniques can also be used in the continuance of benefits process. We have appended as Exhibit B a sample report form used by IRA in evaluating long term disability claims for insurance carriers.

SUMMARY

In brief, IRA supports Section 17 of H.R. 5700. We are excited that the bill recognizes the new resources available to solve old problems. We can provide an information base so that—

Better decisions can be made earlier in the disability detemination as well as in the continuation of disability benefits process;

Significant dollars can be saved as the result of elementary, unnecessary levels of decision-making in evaluating claims; and

The government can be more responsive to its citizens.

We can offer on-going service to recipients of benefits in order that they can again become productive. We stand willing and anxious to be part of the solution.

Sincerely yours,

V. GORDON CLEMONS, *President.*

Exhibit A

A Brief Description of IRA Services

IRA provides rehabilitation evaluation and related services to individuals at the request of insurance companies, self insured corporations, claims consultants and administrators, and government agencies. All total, IRA serves more than 1000 such organizations. The insurance companies pay our fees. Our services are extended in connection with various kinds of insurance coverages - mostly workers' compensation, long term disability, and automobile.

Our specialists perform a wide range of services starting with medical care coordination. They meet with the client's physician. They visit the client's job site and perform a job analysis. A job analysis is an evaluation of the physical and mental requirements of a specific job. The job analysis is important because two jobs with the same job title in two different companies may differ significantly. We also provide job placement assistance.

While we do not do "hands-on" work like medical treatment, nursing, occupational therapy, physical therapy, or psychotherapy, we do try to identify the client's capacity to perform substantial gainful employment and we do try to help the client achieve those goals in the earliest possible time.

Exhibit B

international rehabilitation associates inc.

VOCATIONAL CAPABILITIES EVALUATION

The Vocational Capabilities Evaluation is designed to address two issues basic to the LTD Claims Examiner's or Approver's job:

- Can the disabled return to gainful employment at the present time?
- Is the disabled capable of returning to gainful employment in the future?

This evaluation provides a comprehensive analysis for the basis of this decision. Additionally, in those instances in which placement potential does exist, the specific recommendations to achieve that goal are outlined.

The price for this service is billed to our regular customers on a flat fee basis of   and to our bulk customers on a basis of   which includes all costs associated with our scheduling and conducting the client contact and providing a summary report. If an attorney is involved in the case, obtaining his approval is billed over and above the flat rate as well as would be any contacts to other parties or follow-up work.

NOTE: The flat fees apply to cases which involve contacts to clients within a reasonably accessible geographic area. An unusual exception involving a client in a rural area might precipitate the need for additional mileage and/or travel/wait billings.

VOCATIONAL CAPABILITIES EVALUATION

TO		Attention Of
FROM		District
SPECIALIST	Your File Number	Date of Event
DISABILITY	IRA File Number	Date of Report
CLIENT NAME, ADDRESS	EMPLOYER/INSURED	
PHONE	S S #	

REEMPLOYMENT POTENTIAL/RECOMMENDATIONS

1. Can client return to work now? Yes ____ No ____

(If yes, brief statement regarding physical ability to return to work, specific availability of appropriate work to return to, and the necessity of rehabilitation to achieve job placement. If rehabilitation is needed, recommend the specific activities needed to achieve return to work, including such things as:

Labor Market Survey
Job Goal Development
Job Seeking Skills Development
Modifications/Removal of Architectural Barriers
Job Analysis
Job Search

(If rehabilitation not needed for return to work now, recommend closure.)

2. If client cannot return to work now, will the client be able to return to work at any time in the future? Yes ____ No ____

(If yes, brief statement regarding when, under what conditions placement would be possible, and recommendation of the specific activities needed to achieve return to work, including such things as:

Labor Market Survey
Job Seeking Skills Development
Job Goal Development
Modifications/Removal of Architectural Barriers
Job Analyses
Job Search
Psychovocational Assessment (PVA)
On-The-Job Training (OJT)
Training/Retraining

Schooling
Additional medical treatment/evaluations/assistive devices, etc.
Need for doctor and/or employer contact (s)

(If no, indicate major reasons why client will not be able to return to work again and recommend closure.)

VOCATIONAL EVALUATION/EMPLOYABILITY ASSESSMENT

(To present summary (conclusions/implications) regarding assets and liabilities addressing such things as:

Job Readiness (Physical/psychological ability to seek employment)
Job Seeking Skills
Job Goal (What, where, time frames)
Salary Requirements
Medical Release for return to work (existent, attainable)

EDUCATIONAL/MILITARY BACKGROUND

DATE CONTACTED/LOCATION

AGE	DATE OF BIRTH	PLACE OF BIRTH	HEIGHT	WEIGHT NOW	PRIOR TO DIS

NAME AND LOCATION OF SCHOOL	DATES/ATTENDED Mo Yr	Mo Yr	GRADUATED Mo Yr	COURSE	MAJOR	MINOR	DEG
HIGH SCHOOL							
COLLEGE(s)							
TECHNICAL & BUSINESS TRAINING							

	GRADE AVERAGE	FAVORITE SUBJECT	MAJOR ACTIVITIES
HIGH SCHOOL			
COLLEGE			

REASON FOR DISCONTINUANCE OF EDUCATION (if applicable)

MILITARY TRAINING	ACTIVE DUTY DATES FROM TO	DATE & TYPE DISCHARGE

HOBBIES & INTERESTS

EXPENSES	MONTHLY	INCOME	MONTHLY
MORTGAGE OR RENT	$	SOCIAL SECURITY OR CPP	$
AUTO	$	UNEMPLOYMENT INSURANCE	$
FOOD	$	DISABILITY INCOME	$
UTILITIES	$	VETERANS PENSION OR COMP	$
CLOTHING	$	OTHER	$
INSURANCE	$	OTHER	$
LOANS	$	TOTAL	$
MEDICAL & DENTAL	$	FINANCIAL SUMMARY	
OTHER	$		
OTHER	$		
TOTAL	$		

EMPLOYMENT AT ONSET OF DISABILITY

FROM		FIRM NAME AND ADDRESS	ESTABLISHED WEEKLY WAGES	SALARY	
MONTH	YEAR			START	LAST

DETAILED JOB DESCRIPTION & JOB TITLE

COMPREHENSIVE WORK HISTORY

EMPLOYER	FROM	TO
ADDRESS	WAGES: START	LAST
JOB TITLE	D.O.T. CODE	
DESCRIPTION OF TASKS AND SKILLS		
REASON FOR LEAVING		

EMPLOYER	FROM	TO
ADDRESS	WAGES: START	LAST
JOB TITLE	D.O.T. CODE	
DESCRIPTION OF TASKS AND SKILLS		
REASON FOR LEAVING		

TRANSFERRABLE VOCATIONAL SKILLS AND ABILITIES

(To address both vocational and avocational areas to present a comprehensive picture of:

- Actual task abilities developed through previous employment
- Skills and abilities developed and demonstrated through hobbies, non-employment activities
- Interpersonal abilities - demonstrated "people" skills, previous experience in employment and non-employment situations.

MEDICAL STATUS AND RECOVERY PROFILE

- To present current subjective and objective assessments regarding such things as: ADL's, physical tolerance, physical limitations, pain, etc.
- To present projected prognosis regarding future treatment needs and prognosis for future recovery.

FACTORS AFFECTING EMPLOYABILITY - INCLUDES ASSETS/STRENGTHS VS. LIABILITIES/LIMITATIONS

To Address Such Things as:

- Environmental Restructions:
  - . Architectural barriers
  - . Travel (independence, availability of public/private transportation, etc.)
- Family dynamics/influence
- Job Retention Skills:
  - . Absenteeism
  - . Tardiness
  - . Ability to get along with peers and supervisor
  - . Quality and quantity of work
- Physical factors preventing/facilitating return to work
- Mental Capacity
  - . Educational background
  - . Intelligence
  - . Learning capacity
- Communication Skills
  - . Expression
  - . Comprehension
- Level of self confidence
- Financial Need
- Expressed job goal interests/lack of same/ assessment of ideal work environment
  - . Existence
  - . Realisticness
- Existence of transferrable skills and abilities
- Age, weight, etc.
- Motivation - attitude and desire for return to work
  - . Objective and source (ie: financial, self esteem, etc.)
  - . Subjective - regarding degree of motivation and validity of objective findings.

international rehabilitation associates inc.

HEALTH CARE EVALUATION

The Health Care Evaluation is designed to impact on the acute stage of illness or injury when we have the greatest potential to effect the quality and timeliness of recovery. The effect of intervention at this point is cost effectiveness in medical management through utilization of Registered Nurses to identify and evaluate the specific medical factors requiring control and follow-up action.

	Option I	Option II	Option III
	Client Travel/Wait Report	Client/Family Physician Travel/Wait	Client Physician Family * Travel/Wait Report
Non-Bulk Customers			
Bulk Customers			

*Option III is typically requested when a client is hospitalized or housed at a different location than the family.

NOTE: The flat fees apply to cases which involve contacts to clients, families, and physicians within a reasonably accessible geographic area. An unusual exception involving a client in a rural area might precipitate the need for additional mileage and/or travel/wait billings.

International rehabilitation associates
rehabilitation services

CONFIDENTIAL REPORT – *Follow up*

To		Attention Of
From		Region
Specialist	Your File Number	Date of Event
Disability	IRA File Number	Date of Report
Client Name, Address	Employer/Insured	
Phone / S S #		

To implement a Rehabilitation Plan, we make the following Recommendation(s)

HEALTH CARE EVALUATION

Medical Authorization: Yes ____ No ___

Present Medical Status -

- Diagnosis
- Hospital/Facility
- Primary Treating Physician (name, address, phone, speciality)
- Consulting/Secondary Treating Physicians (name, address, phone, speciality)
- Other significant Health Care Professionals (OT, PT, Speech, Public Health Nurse, etc.)
- Diagnostic Studies/Results
- Treatment Program (what specifically, frequency, duration, time frames, results/response)
  - medications
  - therapy (PT, OT, Speech, ADL)
  - procedural treatments (dressing changes, turn/prop, soaks, trach care, etc.)
  - surgical intervention
  - protective measures (isolation, restraints, etc.)
- Degree of stability
- Health Variables (symptoms, limitations, ADL's, complications, family)
- Relevant medical history (patient and family)
- Patient/Client Awareness (understanding of diagnosis, treatment program, prognosis)

Recovery Profile/Prognosis

- Diagnostic Studies (what, when, why)
- Medications (chemotherapy) - (what, why, duration)
- Surgical Intervention (what, when)
- Therapy (what, in-patient/out-patient, frequency, duration, goals)
- Hospitalization/Extended Care (duration, where, why)
- Attendant Home Care (why, duration)
- Public Health Services (what, why frequency, duration)
- Equipment/Materials (what, why, duration)
- Medical Assessment/Physician Visits (frequency, duration)
- Discharge (when, to where, etc.) (either facility or doctor's care)
- Anticipated Capabilities/Anticipated Functional Limitations/ADL's (what, when, etc.)
- Client/Family rehabilitation potential

Health Management Recommendations

What IRA will need to do to:

- coordinate health care services
- provide information to the account
- coordinate discharge planning
- coordinate future treatment
- evaluate, recommend and coordinate community resources
- secure needed equipment, hardware, prosthesis
- coordinate involvement of another medical speciality

Texas Rehabilitation Commission,
Austin, Tex., March 10, 1982.

Hon. J. J. Pickle,
Member of Congress,
U.S. House of Representatives,
Washington, D.C. 20515.

Dear Mr. Pickle: H.R. 5700, the "Disability Amendments of 1982" proposes major alterations of various areas of the disability program that will have a direct impact on future state agency operations. The Texas state agency wishes to make a statement of position concerning the items presented in this resolution.

We are in favorable agreement with the general concept of attaining uniformity in decision-making as expressed in Sections 6, 7, and 8 and encourage progress in this area.

Section 2—"Continued payment of disability benefits during appeal" and Section 5—"Closing of the record on applications involving determinations of disabilty; disability decisions, appeals and reviews" present a problem of major porportions to state agency operations.

1. The incorporation of the evidentiary hearing into the reconsideration process presents such logistical problems to states with large geographical boundaries that decentralization is virtually assured. As written, Section 5 contains an option for relinquishing, under the terms of the Federal State agreement, responsibility for preparing the reconsideration determinations. State agencies such as Texas may be forced by the impact of logistical difficulties to exercise this option.

2. The closing of the record after reconsideration is intended to assure uniformity in evidentiary review by both DDS and the ALJ. As written Section 5 states that the ALJ shall remand back to DDS for redetermintion any request for reconsideration in which additional evidence on the same impairments is submitted after the reconsideration decision (unless the applicant opts to waive review of the evidence.) If the applicant submits allegations of a new or worsening of the impairments after the reconsideration decision, a new application must be filed. In either situation, DDS will be required to adjudicate the remanded or new claim. We see this provision resulting in higher DDS workloads as well as the handling of an individual's claim repeately in a short period of time.

3. It is our opinion that lengthening the reconsideration appeal period from 60 to 180 days (pre-1976 criteria) will have little impact on the timing or number of reconsideration requests filed. While it is often advantageous to review a claim after 3–6 months, most individuals can be expected to file a reconsideration request promptly in the attempt to obtain the disability check as soon as possible.

Section 16—"Payment for medical examinations in making disability determinations" will have a punitive impact on states with adequate fee schedules. Contracting with a fiscal agent has the potential of stripping the state agency of the managerial control of the consultative examination process that the payment approval now provides. The payment delays historically associated with medicare carriers will have a deleterious effect on state agency efforts to recruit and maintain examining panels. We are therefore opposed to the mandatory participation in this concept. We are, however, aware of rate problems existing in some States. As an alternative we suggest the consideration of 1) allowing DDS participation in the fiscal agent contract as an option, depending on the needs of the state and 2) vesting the fiscal agent with only payment and accounting responsibilities, allowing the participating DDS's to retain managerial responsibilities, including approval for payment.

We have no disagreement with the remaining sections of this resolution. Thank you for the opportunity to state our position.

Sincerely,

Dale Place,
Deputy Commissioner,
Disability Determination Division.

St. Albans, Vt., *March 23, 1982.*

John J. Salmon,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

Dear Mr. Salmon: I am an attorney working for low-income people and I recently reviewed summaries of the proposed changes in the disability provisions of the Social Security Act. I feel that a number of these proposed changes will have very harsh effects on Social Security applicants and recipients. Specifically, I would like to comment on the following proposed changes:

(1) Closing the evidentiary record after reconsideration. I am an attorney who does many disability cases. In my state, Vermont, disability applicants who often cannot read and write ask for reconsideration and are systematically turned down. They don't make it into my office until they have requested a hearing before an ALJ. Most of the time, there is much other medical evidence available which the state agency did not consider. The applicant has no idea what Social Security has in its file for medical reports and it is only after I have reviewed the file and talked with the client about what is there or not there that additional evidence is made known and developed. Often, my clients have extremely limited IQ's or have severe mental problems which they are not able to articulate. They will have told Social Security that they have a "bad back" or "don't know why they can't seem to hold a job" and their mental and psychological problems are never addressed. In these cases it is essential to be allowed to present medical evidence at the ALJ or even Appeals Council stage without the applicant having to file a new application and to go through the process again (with a net loss in benefits for the entire interim period). Finally, on this point, the clients that I see often have had no further development of their cases on their requests for reconsideration done by the state agency. Rather, the prevailing practice seems to be that their file is simply transferred to another person at the state agency who calls them up to see if they have seen any more doctors and who then denies their application again. At no time is an in-person interview done with the applicant or any exploration done of medical or psychological problems which the applicant might not be able to articulate well.

(2) The proposal to not withhold attorneys fees and to exempt Social Security cases from the attorneys fees available under the Equal Access to Justice Act. As you know, there have been severe cutbacks in legal services funding which have traditionally handled Social Security, SSI, and Medicaid disability appeals. The possibility of fees being withheld has provided incentive to the private bar to develop the special expertise needed to do disability cases. At a time when other sources of representation are diminishing, private attorneys should be encouraged and one way of encouraging them is to retain the withholding of attorneys fees. Given the fact that Social Security benefits are exempt from attachment by creditors, attorneys won't bother with these cases if they have no assurance of being paid.

(3) The recency of work tests will only further restrict disabled people from being able to obtain Social Security benefits. Many disabled people receive worker's compensation or pensions through work or insurance benefits when they initially become disabled and only when these are exhausted do they turn to Social Security disability benefits. It is not that these people are not disabled, rather, that they get by without asking for government help as long as they can. Additional "recency of work" requirements just mean that people have to fall back on SSI and state welfare benefits instead of on Social Security benefits that they contributed towards when they were employed.

The overall tone of the proposed new changes seems to be one of making an unwieldy, unresponsive system even more so. I have done disability cases for 5 years now and the trend seems to be more and more to deal with applicants only on paper and not to treat them as individual people. It is impossible to quantify pain (the state agency in Vermont *never* takes pain into account when it makes its initial and reconsideration decisions) for example, and I know of many truly disabled people whom no employer would ever hire who are "not disabled" according to the bureaucrats who have never spoken to them in person.

I hope that these comments have been helpful to you.

Thank you.

Sincerely,

PAULA J. KANE, *Attorney*.

LEGAL ASSISTANCE FOUNDATION OF CHICAGO,
Chicago, Ill., March 30, 1982.

Re Comments on H.R. 5700.

Mr. JOHN J. SALMON,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. SALMON: The Legal Assistance Foundation of Chicago respectfully submits the following comments on behalf of the thousand or more Social Security and SSI clients we serve each year.

I. ALTERATIONS IN THE RECONSIDERATION PROCESS

Section 5 of the proposed amendments is purportedly intended to strengthen the reconsideration phase of the administrative adjudication of claims by providing for face to face confrontation between SSA personnel and claimant and by closing the record at the reconsideration stage; by extending the period of reconsideration appeal from 60 days to 6 months; and by allowing, or in some cases requiring, ALJ's to remand from the hearing back to the reconsideration level for further development. While this amendment may initially appear to have laudatory goals, it is in reality on many levels a prolematic and indeed dangerous departure from the status quo. Consider, for example, the following:

A. Cost

Face to face reconsiderations will require either that state agency personnel be located in or travel to all parts of the state, or that claimants—who, it must be remembered, are severely physically or mentally impaired—be forced to travel to a centralized State Agency location. If the State Agency offices are decentralized or its personnel ride circuit, additional costs are obvious, especially in the many large states where populations may be disbursed or where geography makes travel difficult. If State Agencies remain centralized, who will bear the cost of conveying claimants and their witnesses to the site of the reconsideration meeting? If the claimant must bear that cost, then many claimants will have to forego their right to such a meeting because of lack of funds, lack of means of travel or potential danger to their physical or mental health.

Additional, but equally important, costs would arise with respect to training of personnel who would need to become familiar with the proper elements of the applicable legal standard for assessing disability (only parts of which they now consider), the weight to be assigned different types of evidence, and at least the rudiments of due process so that the reconsideration meeting results in obtaining a more complete, meaningful record.

B. Delay

The Social Security Administration process is not quick. While SSA has talked about insitituting time limits, even apart from being judicially or congressionally ordered to do so, it has within the past 6 months stated its categorical refusal to impose any time limits on the decision making processes of its four administrative stages. The initial and reconsideration phases are consistently the most expeditious. If now the process is altered to provide for a face to face reconsideration meeting, either the State Agency staff will have to be substantially increased or the bottleneck of pending claims will become impossible, and delays will be even more unconscionable then they are now. [See also Sections C and D below regarding the potential for delay by closing the record at reconsideration and by altering the insured status requirement, respectively].

C. Closing the record at reconsideration: More complexity—less responsiveness

Under the present system a claim moves in a linear fashion from an initial application thru Appeals Council Review. In this system only the Appeals Council, under specified circumstances, can remand a claim for further adjudication by an ALJ. This is a sensible system which, by and large, provides justice to claimants in that ALJ's are independent adjudicators, trained as lawyers in the form and substance of due process, who are required to consider all relevant evidence and to apply the proper legal standard.

Unfortunately, the proposed adjudicative system creates a process which could easily result in cases being shipped endlessly back and forth between State Agency and ALJ, sort of interminable "passing the buck." This possibility arises because the ALJ may remand to the State Agency when new medical evidence is submitted at a hearing or must remand where there are additional impairments alleged or a condition worsens after a reconsideration decision. Consider for a moment the practical effect of these proposals:

1. Files must be physically transferred more times from State Agency to OHA and back. Result, more time, potentially more lost files, and evidence which never catchers up with the file folder.

2. Who really takes responsibility for developing a claim? The State Agency by its own volition or the State Agency after remand, with or without instructions from an ALJ? Or will we begin to see split decisions or adjudications arising: medical by State Agency, vocational etc. by ALJ's. The result, confusion as to adjudicative responsibility and authority and the loss of claimants right to a fair and reasonably

prompt decision. Not only will claims get lost but claimants will get lost or give up in despair and frustration.

D. Additional insured status requirement

Under current law a disability claimant must demonstrate 20 out of 40 quarters of coverage in order to be currently insured. Under § 9 of the proposed amendments claimants would not only have to meet the 20/40 standard but would also be required to show more a recent work connection by meeting an 8 out of 24 quarter standard. This additional restriction unfortunately demonstrates that the Committee is losing sight of several very important factors:

1. The disability standard is already a very hard burden to meet. Even without further amendments it is inherently exclusive rather than inclusive.
2. When § 9 (8/24) is read in conjunction with § 5 (mandatory or discretionary ALJ remands), it is apparent that many cases are likely to expire (along with claimants) in an administrative bureaucratic limbo, while files are passed back and forth between DDS and OHA, and while the claimant's insured status runs out. The most likely result of this unfortunate scenario is that no case will ever escape this administrative bog to get to federal court or even to a Social Security court for a full and fair adjudication.

II. ADJUDICATION GUIDELINES (§ 7)

The sources of law have heretofore been relatively straightforward, understandable and accessible and akin to sources of law in other federal admininstrative forums: The statute, 42 U.S.C. § 401 et seq.; the federal code, 20 C.F.R. Part 400 et seq. the Claims Manual (for internal SSA policy and procedures) and case law as it has developed in the federal courts over many years.

Now, pursuant to § 7, adjudicative guidelines—without any reference to the statute, to the Claims Manual or to applicable, long-standing case law—would be binding on all level of the administrative process, and would be limited to the regulations, Social Security rulings and POMS in that order of priority. By this amendment the Committee is validating a manual that (a) has not yet been completed; (b) in many sections directly contradicts the Social Security regulations (see, for instance, the provision regarding pain) and (c) has never been published and therefore violates the provisions of the Administrative Procedure Act which requires notice and an opportunity for public comment.

Even through priority of usage is set forth in the proposed amendment, it is unfortunately true that in our experience of 10 years, the State Agency personnel to date have no knowledge of, training in or access to anything other than the Claims Manual and now POMS. Thus even while the Social Security regulations theoretically have priority over POMS, their employment would be entirely unlikely, nay academic, in practical reality. Thus, the State Agency will still ewmploy a different standard and a different set of criteria even if the proposed guidelines were proper—which they are not.

III. SOCIAL SECURITY COURT (§ 12)

The proposed amendment to establish a Social Security Court is purportedly justified on four grounds. First, unacceptable variances in how cases are decided by State Agencies on the one hand, and ALJs and Courts on the other; second, that the Article I judges appointed to the Social Security Court would have more expertise then District Court judges currently have; third, that a Social Security Court would provide case law precedent which would be binding on all levels of adjudication; and fourth, a Social Security Court would reduce federal court congestion and could more expeditiously handle cases.

This proposal constitutes radical and major surgery on an accepted, traditional system of administrative review, and for it to be justified the need for such alteration must be equally radical and major. For the following reasons, we do not believe such a need exists.

1. Unacceptable variances.—We agree certainly that State Agency decisions differ from ALJ and court decisions. The reason that they differ is easily identified: the State Agencies only evaluate whatever medical evidence they collect. They rarely make a concerted effort to collect all available evidence. They never seriously or fully consider non-medical factors (age, education, past work history), they never consider subjective symptoms (such as pain), and they do not attempt to maintain the record up to date, so that often all they look at are old, stale or incomplete documents. Thus the State Agencies not only fail to develop a complete record but, in addition, irrespective of the record they have, they apply a (wrong) more restrictive standard to evaluate disability claims. On the other hand, ALJ's and courts, who are more skilled in legal analysis and better informed on the law, are more careful to consider all relevant elements of a claim. Thus, the outcome differs. Such a fact, rather than justifying the removal of Social Security cases from federal courts of general jurisdiction, mandate that State Agencies be overhauled, that their employees be properly trained and that they be required to properly evaluate all the evidence and, equally import, properly apply applicable law.

2. Judicial Expertise.—Given the large body of thoughtful, well-considered judicial opinion that characterizes the work of the District and Circuit courts in dealing with Social Security cases over many years, it is hard to see what expertise is currently lacking in those courts. It is to be feared that if a Social Security Court is instituted, what will be lost will be far greater than what will be gained. The federal courts have proven themselves to be both well informed and independent. Could the same be expected of Article I judges, appointed by the President, subject to reappointment every 10 years with positions therefore subject to political pressure of whatever persuasion? We fear not.

3. Precedent Setting Case Law.—This concern strikes us as somewhat ironic, given the vast, well-considered array of judicial opinions in each jurisdiction across the country. Why is Social Security not now simply required to take cognizance of such precedent? Why suddenly, should the decisions of an entirely new entity, without any special expertise, without any history of demonstrated ability, become binding on and precedent setting for the whole country? The wisdom behind this rationale for a Social Security Court is highly questionable.

4. Reduce Congestion and Expedite Claims Adjudication.—Not unlike the dichotomy discussed above (§ III, 2) which seems to trade off expertise for independence of judgement, here the proposed trade-off appears to be speed for justice and equality of treatment. By creating a special court for Social Security claimants, Congress is telling such claimants that they are not worthy of the consideration of traditional avenues of redress. Can we really justify this grave breach of the right to equal treatment under the law on any ground, especially in the absence of some really compelling reason? I know of no showing of congestion in the federal courts sufficient to warrant this proposed "remedy."

Nor can the proposed amendment be justified by the "hope" of more expeditious claims adjudication. Indeed, such a hope is unlikely to be realized, for the Social Security Court as designed is just another level of bureaucracy by a different name. As Congress well knows from long experience, no bureaucracy is quick to act, and because the proposed amendment makes Social Security Court decisions all but unreviewable, what impetus is there, what mechanism would exist, to assure prompt, or even less slow, adjudications.

IV. ATTORNEYS FEES AND EXCLUSION OF SOCIAL SECURITY CLAIMS FROM THE EQUAL ACCESS TO JUSTICE ACT (§13)

It seems unfortunately clear that the practical effect of both the proposed deregulation of attorneys fees and the exclusion of Social Security cases from coverage under the Equal Access to Justice Act (EAJA) is to deprive or discourage Social Security claimants from being represented by counsel.

In the Congressional Record report of March 3, 1982, H. 636, the rationale for exclusion from Equal Access to Justice was stated to be that "the situation contemplated in the (EAJ) statute—abuse of administrative and judicial process in bringing unjustified actions against citizens—is not that faced by the Social Security program." This statement is not just mildly erroneous, it is patently untrue. The incredibly high nationwide reversal rate by ALJ's of cessation case (CDI's) when properly viewed, demonstrates that in the large majority of claims being terminated based on alleged cessation of disability, the Social Security Administration was wrong, i.e. unjustified, in ordering termination.

Obviously, however, the EAJA, does not come into play in Social Security claims until they reach the District Court, and then it is the court which must decide whether or not the Agency's actions were "substantially justified" before attorneys fees will be awarded. Thus an independent judicial decision is necessary separate and apart from a ruling on the merits.

The proposed provisions of § 13, if effectuated, will result in grave harm to Social Security claimants, and is patently unjustified.

V. SOME POSSIBLE ALTERNATIVES

H.R. 5700 demonstrates a real concern about State Agency activity at the initial levels. Unfortunately, the Bill proposes drastic as well as unwieldy and unworkable solutions. No such solutions are necessary or would be effective, if the objective is to provide fair and efficient administrative adjudication of claims.

The Social Security Act presently contains a provision which allows the Social Security Administration to take over any State Agency which fails to properly perform its mandated functions (1980 Amendments to the SSA). If Congress made a few relatively minor changes, certainly less drastic than those now proposed, the State Agencies could not avoid performing their duties, or, if they did, the administration would act to take over their function. We respectfully suggest the following changes be made:

1. That DDS (State Agencies) be required to process claims within specified time limits.
2. That DDS be required to perform all necessary case development, including the collection of all known medical documentation, and that if consultative examinations are ordered, the results be obtained in an expeditious fashion (never have I known DDS to lean on its own consultants to make sure reports are available in a timely fashion) and that they be complete when obtained. (Often things that have been requested are not done or are not submitted and nobody bothers much about getting them.)
3. That the DDS personnel be properly trained in SSA regulations, in evaluating both medical and nonmedical elements of a claim (age, education, work history) and that they be required to evaluate all such elements in their initial adjudication.
4. That DDS be limited to initial adjudications, that the appeal period from an initial denial be extended from 60 days to 6 months, and that the reconsideration stage be done away with.

The rationale for the last proposal should be explained. As the Committee has itself pointed out, the reconsideration stage has become a rather meaningless rubber stamp. If the State Agencies were required to do their job properly, they would need only one opportunity to do it; that is the initial decision. By extending the appeal period from an initial decision, claimants are given time to consider whether they wish to pursue a claim. They would not—as now—need to rush back to file an appeal. If they got better during the 6 months, they would presumably drop their claim; if not, they could pursue it. The appeal, however, would then be directly to an ALJ whose function would continue to be what it is now. This system would streamline the administrative process, reduce administrative costs and expedite the actual claims adjudication time. It would also potentially bring State Agency and ALJ decisions in line (reduce variance in decisionmaking) by imposing on the State Agency the requirement that they properly evaluate *all* relevant evidence as the statute and regulations require.

We appreciate your thoughtful consideration of these remarks.

Respectfully submitted,

BARBARA SAMUELS.

LEGAL SERVICES CORP. OF ALABAMA,
Phenix, Ala., March 22, 1982.

Re H.R. 5700, March 16–17 hearings.

Mr. JOHN J. SALMON,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. SALMON: I understand that the Committee has held hearings on H.R. 5700, Disability Amendments of 1982, concerning numerous provisions of the Social Security Disability program, and that the record is open for additional statements. On behalf of Legal Services Corporation of Alabama, a federally-funded program providing legal assistance to the poor in civil matters in sixty of Alabama's sixty-seven counties, and as an attorney who has practiced in this area for six years, I will comment on one issue under review, the Continuing Disability Investigation Process.

The law is clear that recipients of public benefits are entitled to some due process when an agency proposes to terminate those benefits. The amount and nature of the safeguards required is open to dispute, but some minimum is clearly indicated. We have found that our State Disability Determination Unit is totally ignoring the rights of the disability recipients.

I will illustrate with an example. One of our paralegals represents a client in West Alabama, who received a notice dated February 3, 1982, advising her that her condition had improved effective August 1981, and that October 1981 was the last month she could have been eligible for payment. On the basis of this notice, an immediate overpayment is declared retroactively. The state agency apparently believes it has no responsibility to notify citizens of its decisions in a timely manner. Presumably in an attempt to complete review of a large number of claims in a short period of time, due process rights are being routinely ignored. I review several hundred disability cases a month around the state and such examples are common. Anything Representative Pickle's bill can do to strengthen the redetermination process will be helpful to those individuals dependent on these benefits.

On behalf of LSCA, its staff and clientele, thank you for the opportunity to make these comments. Please feel free to contact me should additional material be useful in your deliberations.

Respectfully yours,

MARILYN C. NEWHOUSE,
Specialist Attorney/Paralegal Coordinator.

LEGAL SERVICES FOR THE ELDERLY, INC.,
Augusta, Maine, March 29, 1982.

JOHN J. SALMON,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. SALMON: I am writing to comment on proposed H.R. 5700, the "Disability Amendments of 1982." I do not have a copy of the bill, so I will attempt to identify my topics of comment in a manner so that you might correlate them to the bill.

A. DISABILITY TERMINATION

(1) The proposal to institute an informal hearing at the reconsideration level, and terminate it thereafter upon introduction of an evidentiary hearing procedure for S.S.I. in D.I. disability terminations at the State agency level contains a partial response to the problem of inadequate State agency determinations, but goes in the wrong direction.

The basic problem is that the State agency determinations are often completely wrong, and are based on inadequately developed records and review of written material, rather than face-to-face meeting with the claimant by those persons actually making the determination, which results in the wide-spread errors in the system.

An evidentiary hearing procedure at the reconsideration level would be one way of attacking this problem. However, rather than an evidentiary "hearing," there ought to be face-to-face review at the reconsideration level, followed by the more formal evidentiary hearing at the Social Security level. Benefits should continue through the ALJ level.

In other words, although it's important to include face-to-face reconsideration, it is equally important to maintain the dignity of these proceedings and the proper attention to procedure which is produced by providing the claimant access to the ALJ procedure. Any State agency evidentiary hearing procedure is not going to rise to this level of appropriate process.

(2) The provision for continuing benefits after the month in which a person is notified of termination, so long as they have been receiving benefits for at least 36 months, is a good one, but should be continued beyond the end of 1984.

(3) Overpayments resulting from a finding that the individual was not disabled in the months prior to the month after the first Notice of Termination is sent should be waived, as the bill provides, if there was no willful neglect in the beneficiary's part. This, and the continuation of benefits beyond termination notices, reflect the reality that the bulk of persons whose benefits are terminated at the initiative of the Social Security Administration in good faith believe that they are unable to work. They are not in a position to make the medical judgment that they have recovered sufficient to continue working. In those few cases where they have made that determination privately, but have neglected willfully to inform Social Security, their bad faith can justify the recoupment of overpayment. However, in the large bulk of cases, this will not be the case.

B. STRENGTHENING THE RECONSIDERATION PROCESS

(1) Closing the evidentiary record after reconsideration, rather than at the ALJ level, is another step backwards. It is an ill-conceived response to the real problem of poor construction of the record at the State agency level. In many cases, that I have seen in my nine years of practice, an individual comes to a legal services office for help in pursuing an appeal to the ALJ, after a reconsideration has been denied.

It is at this point that the attorney is able to discern gaps in the medical record. The individual was not competent to assess whether the medical record was adequate. All that individual knew was that he or she had revealed the names and addresses of all medical personnel relevant to the case, and that the Social Security Administration had undertaken to contact them.

Often, it turns out that the Social Security Administration's contacts have resulted in no records coming back from the physician. To require someone to be remanded to the agency level because good work by the advocate produces existing documents that have not yet been obtained, or new documents which fill in gaps in the record, would result in unnecessary delays beyond the already lengthy delays in processing these cases. Let the proceeding go forward through the ALJ process at this point. Do not penalize claimants because new evidence comes up between the date of reconsideration and the date of hearing.

In no other administrative hearing procedure of which I am aware is the proceeding so restricted as to be a reviews of the record developed below. To deny claimants the opportunity to submit further medical information at the hearing level is to erode the due process protections inherent in a hearing before an impartial decisionmaker. What is the point of a hearing, if no further information can be forthcoming? Is the intention of this provision of the statute that the claimant's testimony at the hearing is to be limited to an argument on the legal effect of the documents submitted below? This provision would be a serious step back from the rights of claimants in Social Security proceedings.

(2) An evidentiary hearing at the reconsideration level in S.S.I. and D.I. are unnecessary, although a face-to-face meeting with the claimant would be extremely valuable, Again, the hearing should remain at the ALJ level, although face-to-face contact with the claimant should be built in for at least borderline cases at the disability determination level preceeding.

C. UNIFORMITY IN DECISION MAKING

(1) The requirement of "own-motion" review of ALJ allowances of benefits is misleading. It would make more sense to review ALJ denials of benefits. At any rate, if such reviews should be undertaken at all, they should include both allowances and denials.

(2) The most dangerous part of the bill, perhaps, is the section making Social Security ruling and the claims manual (POMS) binding upon levels of adjudication. This is an outright denial of due process, and probably unconstitutional. It exceeds the authority of the Legislature to delegate to the administrative branch.

Neither Social Security rulings nor the POMS are regulations promulgated in accordance with the Administrative Procedures Act. Accordingly, they are not subject to advance notice to the public, and comment. There is no law which requires that they be in conformity with the statute; the court in Hanson v. Harris made it clear that the Claims Manual is not law, although it might have some interpretive value.

In our practice, we come across numerous instances in which the Claims Manual adds restrictions on benefits which are not included in the publicly promulgated regulations, and which it is hard to correlate to statutory intent. To require that these be binding, would abdicate the responsibility of the legislative branch to insure that its intention was carried out, and to subject the regulations of the administrative department to review.

Also, there are no formal mechanisms by which claimants can obtain, in a systematic and useable fashion, Social Security rulings. Some of these are published in the Unemployment Insurance Law Reporter which is privately published by Commerce Clearinghouse, at an extraordinarily high cost per year. Claimants cannot be sure of having access to this, even at their State law libraries (as is the case in Maine). Similarly, the Claims Manual has been jealously guarded by district offices of the Social Security Administration, whose staff are hesitant to allow individuals to review the materials contained in it. It is an enormous body of paper work. The only meaningful way to have access to its provisions is to have a copy of it. It recently took this office several months to obtain a subscription.

To elevate Social Security rulings and the Claims Manual to the status of law binding on all levels of adjudication would be to introduce a wholly new chapter in administrative law, and one which we believe would be a retreat from the rule of reason and of democracy. If Congress does nothing else, it should not enact this provision.

(3) Although it is important to have medical courses and continuing education courses on the evaluation of medical impairments, it is questionable whether trust fund moneys should be used, or at least should be expected to bear the bulk of these

costs. Workers Compensation claims, disability claims under pensions and other statutory provisions, all share in the need for instruction of staff in these areas.

(4) An advisory council on the medical aspects of disability is an excellent idea. I admit to being surprised that it was not already in effect.

D. TRADITIONAL REVIEW

(1) The Social Security court proposed in this bill is another massive retreat from the principles of equality of justice. The idea of giving poor people a lesser level of judicial treatment of their disputes with the government has surfaced again and again when the success of poor individuals to obtain access to the federal courts adds to other social forces in increasing the workload of the courts. The existence of Social Security claims, although increasing, cannot be seen as the primarly reason for judicial congestion, however.

If there is congestion in the federal courts and delay, perhaps more judges are needed, or some other efforts must be made to reduce congestion in the courts.[1] Denying Social Security claimants their access to courts of the same dignity and stature as those where other people's disputes are resolved would be a violation of the principles of equal justice.

E. ATTORNEY'S FEES

(1) We would cautiously support the suggestion that attorney's fees no longer be withheld by Social Security. This is based on the fact that this office does not charge fees for our representation, and yet they have been routinely withheld from client's back benefits, and a considerable amount of letter writing and advocacy must be undertaken to spring loose benefits for our clients. Also, presumably clients are competent to make fee arrangements with private attorneys, and there ought to be no need to presume that all clients will neglect to pay their counsel. However, we do not feel strongly one way or another about this.

F. RECENCY OF WORK TEST

(1) The restrictions on the recency of work test make no particular sense. All they will do is cut out those people who are more likely than the general class of claimants to be chronically unemployable, and penalize them for the fact that they did not have the savvy or the means to effect their Social Security application soon enough.

G. INDEXING SUBSTANTIAL GAINFUL ACTIVITIY AND TRIAL WORK FIGURES IS A GOOD IDEA

Thank you very much for this opportunity to comment on behalf of our clients who are claimants for Social Security Disability and S.S.I.

Sincerely,

NANCY BROCKWAY, *Chief Attorney.*

MASSACHUSETTS BAR ASSOCIATION,
Boston, Mass., March 15, 1982

Hon. J. J. PICKLE,
Chairman, Social Security Subcommittee, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR JUDGE PICKLE: This is in reference to HR5700, entitled Disability Amendments of 1982. As Chairman of the Massachusetts Workmen's Compensation Sub-Committee of the Massachusetts Bar Association I am writing for our group as opposed to provisions in the bill providing for closing of the record at the reconsideration level because it would deprive a claimant the right to a full de novo hearing before an independent Administrative Law Judge who is not subjected to agency control or agency bias. Any erosion of the right to a full de novo hearing would be an impingement on a claimant's due process rights. We favor retaining the present hearing process as it currently operates.

We are also opposed to Section 13 of the bill relating to Attorneys' fees wherein it is provided that no federal funds will be certified for payment to an attorney as compensation for claimant representation. This provision will discourage attorney representation since most attorneys in Massachusetts handle these cases on a contingency basis. Under the current system they are assured of payment of their fee, if successful in obtaining an award of benefits. However, if they have to look to the client for direct payment, most attorneys would require a retainer before handling a case. Since most Social Security claimants are not in a financial position to pay a retainer, they will, in essence, be deprived of an important right to counsel. In view of the above, we favor retaining the current system of withholding of 25% of past due benefits, and also making the provisions of the "Equal access to Justice Act" applicable to court proceedings.

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[1] If any cases should be barred from the courts, it is the so-called "diversity" jurisdiction cases, which do not, since *Erie,* apply federal substantive law, and properly belong in State courts.

Sincerely yours,

Louis P. Massaro, Jr.,
Chairman, Worker's Compensation Committee,
Massachusetts Bar Association.

San Francisco, Calif., March 30, 1982.

Re H.R. 5700.

John J. Salmon,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

Dear Mr. Salmon: I am writing to express my disagreement with certain provisions of H.R. 5700 as I understand it. First, I disagree strongly with the attempt to no longer withhold attorney's fees while maintaining control over setting the amounts. I believe the absence of withholding will result in a precipitous drop in both the quality of representation afforded social security claimants and in the number of claimants actually represented by counsel. I think this can be nothing but detrimental although it may well be a desired goal of the current administration.

Second, I see the proposed modification of the recency of work tests as another attempt to further pare down the number of people eligible for benefits. Some illnesses are insidious and, while perhaps not initially at a level of severity required for social security, do eventually manifest themselves in a form sufficiently severe to preclude all work activity and hence qualification for social security disability benefits. I do not see the need for invoking what appears to be another penalty-type requirement.

Third, the proposal to close the evidentiary record after reconsideration seems utterly absurd to me. Often, impairments are over-looked by state agencies or not properly developed even though there may be hints or suggestions from claims workers or statements from clients themselves that further investigation is warranted. My experience with the state agency doing disability reviews has generally been that, for example, if an individual intentionally shoots himself, then complains to Social Security that his leg hurts, the response will be to order an orthopedic examination with absolutely no consideration given to why the person shot himself in the first place. This type of shortsightedness would simply be re-enforced under the proposed change.

Fourth, the proposed definition of pain seems too limiting. Granted, there may be some problems in this area because of the subjective nature of pain. Yet, I think it fairly common experience among us all that some people do experience quite severe pain in the absence of traditional "objective" findings and yet we give credence to their complaints. Some people perceive pain differently than others. There are also some rather esoteric diseases which can often provide a basis for pain not otherwise documented or backed up by such things as X-ray findings, EMG reports, etc.

Fifth, and here I admit I am not sure the proposed changes deals with this point directly, I have heard enough of my social security clients tell me about the three-minute or five-minute examination they got from a consulting Social Security doctor to start believing that there is something wrong with the system of consultative examinations. My experience has been that there is a wide variation in the quality of examiners and the reports prepared. Complaints to me from clients have most often been (but not always) about volume providers of such services. This matter needs further addressing.

I should note here that the bulk of my practice is representing social security disability claimants and I have been doing this more or less exclusively for the past six years. I might add just as a gross generalization that being in the business is getting progressively harder and I worry about this not only for myself but for my clients. Social security disability is already an extremely severe definition of disability and I really do not think it needs further narrowing. I understand that the disability portion of social security funds is in fact quite healthy and I do not see the need for further tinkering in this area.

Respectfully submitted,

ARTHUR L. MEADER, III.

STATEMENT OF THE NATIONAL MENTAL HEALTH ASSOCIATION, ARLINGTON, VA.

This statement is submitted on behalf of the National Mental Health Association (NMHA) a nationwide, voluntary non-governmental organization dedicated to the promotion of mental health, the prevention of mental illness and the improved care and treatment of the mentally ill. NMHA's 850 local chapters and statewide divisions and its more than one million citizen members and volunteers work toward these goals through a wide range of activities in social action, education, advocacy and information.

NMHA has serious concerns about the current operation of the disability insurance program, and several comments concerning HR 5700 which we believe addresses only a few of our concerns.

First, NMHA concurs in the testimony presented to the subcommittee on March 16th by Jane Yohalem of the Mental Health Law Project, and is one of the organizations which submitted the report, attached to Ms. Yohalem's testimony, concerning arbitrary reductions of disability rolls. NMHA, along with the other eleven groups which endorsed that statement, urge:

Congressional hearings, including field hearings, to address the full array of issues in the disability review process, particularly those highlighted in Ms. Yohalem's testimony and the attached report;

A General Accounting Office investigation of the Social Security Administration's practices with respect to determining continued eligibility so as to examine the immediate and long-range impact of current SSA practices on beneficiaries and on Federal, state and local governments;

That beneficiaries not be terminated prior to a full and careful review of the merits of their case by appropriately qualified professionals;

That mentally disabled beneficiaries and those who are homebound be provided with personal assistance (and home visits if necessary) throughout the review process.

The case examples attached to our report, and the numerous calls and contacts which Mental Health Associations across the country are receiving on this issue, make it very clear to NMHA that something is seriously wrong with the current operation of the system. Clearly mentally disabled persons are being denied essential benefits to which they are fully entitled. These concerns are supported by documents written by SSA's own officials. For instance, according to the Chicago Acting Regional Commissioner of SSA, SSA field offices are now concerned because "individuals whom they consider to be obviously disabled, based upon observed bizarre and unusual behavior and interviews in the SSA district offices, are denied." Also, an SSA medical consultant whose statement has already been submitted for the record on these hearings pointed out that it is "practically impossible to (meet the criteria) for any individual whose thought processes are not completely disorganized, is not blatantly psychotic, or is not having a psychiatric emergency requiring immediate hospitalization. In fact, an individual may be commitable due to mental illness according to the state's mental health codes, and yet found capable of 'unskilled work' utilizing disability standards". Finally, the director of the Wisconsin State Bureau of Social Security Disability Insurance stated: "current adjudicative climate involving mental impairments seems to be one of deny, deny, deny . . . based upon a most minimal possible understanding of mental impairments."

It is NMHA's contention that the numerous cases which we have become aware of which have been decided against the mentally disabled person indicate that SSA procedures are now acting to deny benefits to the truly disabled. This is supported by the extremely high rate of reversal at the appeals level.

Another major concern to NMHA is that individuals residing in state mental hospitals who may well be able to function in a community residence, provided sufficient support is available to them and provided further that they can collect SSI payments, are now being denied SSI eligibility and thus must remain in the institution. In other words, not only are those individuals already receiving disability and SSI payments in danger of being returned to institutions because their disability eligibility is being terminated, but many who could make the move out of institutions are failing to get into the rolls. In the long term, this is going to be an extremely costly policy as well as a very inhumane one.

With respect to HR 5700, NMHA finds a number of important and laudable changes to the law in this bill. Especially, we support provisions to:

Continue payment of disability benefits up to the time of the reconsideration (subject to repayment if appeal is unsuccessful), as is now the case for SSI eligible individuals;

Extend the right to due process by establishing an evidentiary hearing at the state agency level for medical terminations (after 1984);

Allowing benefits to be paid for two additional months (to make four months in all) for medical recovery cases if the person has been on the rolls for 36 months;

Waive overpayments of benefits when a finding of "retroactive recovery" is made and the beneficiary was not willfully negligent;

Provide vocational rehabilitation programs for evaluation and job services to "medically terminated" beneficiaries for 1983 and 1984;

Face-to-face conference at the reconsideration unless the reconsideration examiner reverses the initial finding on the record;

Priority for social security cases in Federal courts;

Indexing SGA and trial work levels for increasing wages.

However, there are provisions in HR 5700 to which NMHA vigorously objects, specifically:

Changes in the recency-of-work requirement, which will make it hard for those mentally disabled persons whose condition has deteriorated over the years to become eligible for disability;

Requirements that the internal policy manual of SSA become the basis for determining disability which will lead to decisions inconsistent with the law and regulations.

With respect to the recency-of-work requirement, NMHA is not aware of the need to change the current requirements which appear to have worked well in the past. If individuals qualify for disability, based upon their medical condition, why should we deny benefits to some merely because they have found it hard to hold down a job in recent years?

With respect to the Program Operations Manual System (POMS), NMHA is concerned that an internal administrative document, which is never published for review by and comment from the public, supercede the law and published Federal regulations at the appeals level. One reason for the large number of reversals at that level is that clearly disabled persons (according to the law) have been denied their benefits under the POMS and under internal SSA rulings. Such internal administrative rulings are too subject to political pressures, as well as too remote from Congressional and public review and input, to serve such crucial purpose.

HR 5700 suggests various other changes in the operation of the disability system, which NMHA will not comment upon. However, we do believe that, although there are some useful provisions in this bill, on the whole HR 5700 does not address the heart of the problem—the massive numbers of unjustified, and we believe illegal, terminations occuring throughout the country. Possibly legislation is not the answer to this problem, which is one reason why we, and other disability groups, are calling for a more thorough investigation by Congressional committees and the GAO.

We hope such an investigation will be launched quickly. In the meantime, those provisions in HR 5700 which have broad support, such as those listed earlier in this statement, should be enacted without more ado.

STATEMENT OF HARRY L. HALL, WASHINGTON REPRESENTATIVE, NATIONAL MULTIPLE SCLEROSIS SOCIETY, WASHINGTON, D.C.

Mr. Chairman and Members of the Social Security Subcommittee: The National Multiple Sclerosis Society is the voluntary organization representing several hundred thousand U.S. citizens who have multiple sclerosis and closely related neurological disorders. The Society has about 560,000 members and 130 Chapters with 13 branch Chapters covering the entire United States. For more than 35 years it has supported research to identify the cause and develop a cure for this disabling disease. Our Chapters are deeply involved in helping individuals and their families cope with the effects of MS.

We have appeared before the Committee and provided testimony in the past, as well as working with the Committee staff. We appreciate this opportunity to provide input.

H.R. 5700 has some sections which we wholeheartedly support (Sections 2, 3, 10, 11). We describe our reasons in this testimony.

H.R. 5700, Section 17 is a section which we support subject to technical amendment improvements which we have outlined.

H.R. 5700, Section 9, we forthrightly and strongly oppose. We have focused the bulk of our testimony on this section since it would have an inequitable negative impact on persons who are subsequently diagnosed with multiple sclerosis. We have tried to supply the Subcommittee with the medical and statistical facts which document our deep concern that this Section not be adopted.

We have simply avoided comment on other sections of the bill for which we currently have insufficient perspective to provide a clear judgement, except to note that we have serious question about Section 5.

SECTIONS 2 AND 3

The National Multiple Sclerosis Society is generally in favor of the provisions in H.R. 5700 which tend to make more reasonable the impact on persons and their families who are terminated from the disability rolls as a result of the reevaluations. Multiple Sclerosis is a disease for which there is presently neither a treatment which would alter the long term course of the disease nor even a medical therapy which helps by affecting the disease process itself. There are some therapies for some of the secondary effects such as spasticity, etc. Thus, multiple sclerosis is a disease which at present causes permanent disability. Despite this, and despite the fact that the top physician in the Social Security Administration on medical disability, Dr. Herbert Blumenfeld, has included MS in the list of conditions which do not need to be reviewed every three years, we have heard of numbers of persons with MS whose cases have been reviewed and some whose benefits have been terminated without the opportunity of a face-to-face hearing.

We also support the communication from the Subcommittee to the Social Security Administration which expresses the intent of Congress in passage of the 1980 Amendments and the sense that part of what is currently happening is beyond and in conflict with that intent of Congress.

SECTION 10

We are especially supportive of Section 10(a). The experiences of one of our chapters through a demonstration grant which is highly successful in providing services and placing certain people with MS back into employment suggests that many persons are fearful, some on the basis of conversations with SSA local offices, that engaging in transitional work even below the SGA level will cause a reevaluation on the basis of the medical criteria. Making clear in the law that attempts to get back into the labor force despite a severe disabling condition will not threaten the basic medical eligibility is a positive step which should serve as an incentive for some persons on the roles to try to become employed.

SECTION 11

We are also very supportive of Section 11. A significant problem in the application for benefits by persons with MS is the medical examination documentation. Most of this is caused by physicians' lack of understanding of what information is desired by the Social Security Administration. Also, the proposed Advisory Council on the Medical Aspects of Disability would probably help to improve the medical criteria (listings) and the manner in which they are interpreted for conditions such as MS.

SECTION 17

P. 53, lines 20-25: Why limit the VR services which will be supported to "evaluation services" as described in the Rehabilitation Act, Sec. 103(a)(1)? There are 10 other VR services listed in the Rehabilitation Act under scope of Vocational Rehabilitation Services. Apparently you intended to limit it to evaluation services. We doubt that providing reimbursement for only a small portion of the rehabilitation services usually necessary to successful reemployment will be sufficient incentive to State VR Agencies. Moreover, because State Agencies are able to serve less clients due to appropriations, it would cause frustration among clients who receive positive evaluations but cannot obtain other services.

P. 54, lines 2-4: Restricting the "performance of gainful activity which lasts for a continous period of nine months, . . ." will do the same thing the recent change in the law did; namely, to cause State VR Agencies to avoid attempting the rehabilitation process with those persons disabled by a disease or condition which is active rather than static. For example, because persons with multiple sclerosis may experience unpredictable exacerbations and thereby, for new medical reasons, not be able to be gainfully employed for a "continuous" nine months, they are considered bad risks from the standpoint of reimbursement from the Trust Fund to the State VR Agency. This is a very shortsighted restriction in the sense that some persons with MS are statistically good prospects for rehabilitation over a longer period. Reimbursement under the current law should be permitted for those persons whose term of substantial gainful activity is stopped or interrupted by a change in medical condition prior to the nine months (provided that changed medical condition was not anticipated by medical prognosis). Payment for the costs of VR services should be provided when the period of substantial gainful activity is stopped or interrupted by a new or worsened medical condition.

P. 54, line 14ff: We strongly support the concept of an alternative arrangement between the Social Security Administration and "other public or private agencies, organizations, institutions, or individuals." We are not sure it should be restricted to a "contract"; possibly some less precise agreement would be sufficient between the Social Security Administration and a voluntary organization such as a chapter of the National Multiple Sclerosis Society.

SECTION 9

We are forthrightly opposed to this section. It would affect a smaller number of disabled persons than last year's Administration proposal for a six out of thirteen quarters recency of work test, but it would still impact in an uneven and discriminatory fashion on persons who become disabled over a period of time rather than as a result of a single event.

Many persons with MS become disadvantaged in the work force or are forced to cease employment for periods of time,[1] before the disease progresses to the point where they would meet the medical criteria as currently interpreted. Additionally, the affirmative diagnosis of MS often takes years: people become unable to sustain employment without knowing the medical reason. The average period from onset of significant symptoms to diagnosis is 4 years.[2]

To add to this problem, about 65 percent of all persons diagnosed with MS are women, nearly all of whom are in their childbearing years when the disease first manifests itself.[3] If a woman temporarily withdraws from the work force for childbirth and early childhood care with every intention of returning to the work force, but is unable to do so because of a medical problem manifesting itself near the time she intended to return to work and which is only diagnosed several years later, she probably would lose her eligibility even though she had contributed for many prior years into the system. This pattern is complicated by the fact that divorce is very high among those effected by multiple sclerosis causing many individuals to depend on their own resources and eligibility for benefits.

For reasons which are not able to be scientifically explained the proposed recency of work test would have an even stronger negative impact on those citizens in the southern portions of the nation who will be diagnosed with multiple sclerosis. This is because the average interval between onset of symptoms and diagnosis for those residing below the 37th parallel is one to two years longer.[4]

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[1] Executive Summary, "Prevalence, Incidence and Costs of Multiple Sclerosis," A National Study, NIH-N07-NS-4-2335, NIH-N01-NS-0-2325, Conducted for: National Institute of Neurological and Communicative Disorders and Stroke, National Institutes of Health, Department of Health and Human Services, Conducted by: National Analysts Division, Booz-Allen & Hamilton, Inc. December 1980.

P. vii: "The MS prevalence population is generally well educated (36% attended college). Although nearly all have worked at some time (93%), only about one-fourth (24%) currently hold jobs. Median household income is somewhat lower (approximately $2,300 less) than that of the U.S. in general."

P. xii: "Employment changes are reported by a substantial percentage of patients, as 42% claimed they had to leave or were dismissed from a job because of their illness. Furthermore, when patients were forced to make occupational changes (8%), those in blue collar jobs typically had to find employment that was less demanding and strenuous."

[2] Ibid.

P. viii: "With regard to the disease characteristics of the MS prevalence population, 79% are classified as 'probable' MS and the remainder as 'possible' MS. The mean age at onset of symptoms is 33 years of age and the mean age at diagnosis is 37. Generally, a four-year interval is experienced between onset of symptoms and diagnosis for the average patient."

P. ix: "A six-year interval between date of onset and diagnosis is observed for non-whites as compared to four years for whites."

[3] Ibid: Pp. viii-ix: ". . . females are, on the average, two years younger at the time of onset and of diagnosis than males."

The bill is written in such a way that a person would lose eligibility for benefits (and thereby also be effected in terms of Old Age and Survivor benefit levels because they would not benefit from the "freeze") if a person has not been employed in covered employment at or above the SGA level for ". . . not less than 8 of the quarters during the six-calendar-year period ending with the calendar year in which the onset of the disability occurred . . .". This is a mixture of "quarters" and "calendar years" which is an inequitable recency of work criteria depending upon whether the onset of disability occurs in January or December of a calendar year. it is not the same as 8 out of 24 quarters, or 2 out of 6 years, both of which are used in various places to describe the bill.

The bill as written really means that a person who had worked 20 or more quarters consecutively and thereafter had an erratic pattern of work for the most recent 20 quarters, and became disabled in January of a calendar year, would have to have worked 8 quarters in the most recent 21 quarters.

In the "Detailed Summary" included in the March 3rd Congressional Record on page H636 there is a paragraph which reads: "This proposal, in its strictest form, still allows for a recent three-year gap in the individual's employment record."

The gap could be more than three years on the basis of the bill as written. If the bill read 8 out of 24 quarters, it clearly would leave a four year maximum gap.

Given the above mentioned apparent inconsistencies, we would like to ask you to cause to be conducted a reexamination of the budgetary implications and how many people would be effected by Section 9 and what are some of the general characteristics of people expected to be effected.

We believe that the Social Security Administration would have to concur with our view that persons with multiple sclerosis and other types of unpredictably erratic and often progressive disorders especially those with long intervals between onset and diagnosis, would be effected in great disproportion to their representative proportion on the disability rolls.

When disability is caused by medical conditions which often takes years to diagnosis, and, or is the result of a medical condition which frequently exhibits a clinical course of progression or exacerbation and remission stages or is otherwise degenerative causing an individual to be unable to work but not clearly severe enough in the earlier stages to permit a worker to meet the medical criteria for disability, no new recency of work criteria should be applied. If it were possible to prepare adequate language in the bill to make such an exemption and if it was concluded that regulations could be developed and administration of the exemption could be handled, the National Multiple Sclerosis Society could support a revised Section 9. This might be done through an exemption included in Section 9 or by increasing by 12 (presuming the bill would be changed to read 8 of 24 quarters) the number of months prior to the application for benefits such persons could claim as the "onset of disability" date.

Currently, a disabled worker can file an application after the onset of disability. He or she could file for retroactive eligibility of 17 full calendar months, and except for the initial five consecutive month waiting period will receive benefits providing he or she meets all the eligibility requirements. Thus, there is the opportunity to recover 12 months of benefits prior to the application date.

This means that the "onset of disability" can be effectively predated by one year, or 4 quarters prior to application, and it is at the point of determined onset, not the date the application was filed, that an applicant must have insured status.

Since some persons with MS who had intended to remain in the labor force have lost their insured status under the current law, we are certain that shortening the period would substantially increase the number of persons effected. The average interval from onset to diagnosis means that nearly half of those with MS are at the margin now; more than half among those living in the southern half of the U.S., or non-white, or in the lower income status are at the margin on the basis of delayed diagnosis.

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[4] Ibid: Pp. ix-x: "The most revealing findings are evident between high and low risk region patients. Proportionately more male and non-white MS patients reside below the 37th parallel, although no diference in age on prevalence day between regions observed. Age at onset varies, with low risk region cases being two years younger, on the average, while no differences in age at diagnosis are shown. A one to two year longer interval between onset and diagnosis for persons in low risk areas results. Lastly, a larger percentage of low risk region cases (86%) are classified as "probable" compared to high risk region cases (77%). Similar to non-white cases, longer observation may yield more definitive diagnosis. There is no apparent reason or age at onset differences; however, Detels (1980) found similar results."

Markup of H.R. 5700 should eliminate Section 9. Until a solution can be found which does not inequitably penalize persons because of the type of disability they happen to develop the current law should not be changed.

SECTION 5

We have serious question about a process which would seriously curtail the introduction of documentary evidence after the "reconsideration level". Because of the nature of the disease, the general problem of medical records related to the nature of the disease, and the process of interpreting the current medical criteria, many persons disabled by multiple sclerosis have had the experience of gradually accumulating appropriate documentary evidence.

STATEMENT OF CAROL BELLAMY, CITY COUNCIL PRESIDENT, NEW YORK CITY

PASSING THE BUCK: FEDERAL EFFORTS TO ABANDON THE MENTALLY DISABLED [1]

I. Introduction

Over 160,000 people receive Social Security Disability (SSD) and Supplemental Security Income (SSI) benefits each month in New York State as a result of being mentally disabled and unable to work. Many of these people are state psychiatric hospital dischargees, living in single room occupancy hotels, adult homes and community residences. They are dependent on Federal disability benefits to buy food and pay the rent.

Thousands of these chronically ill, mentally disturbed men and women will lose these benefits due to a federal initiative to re-examine the eligibility of all disabled Social Security beneficiaries. While the publicly-stated intent of this action is to eliminate improper payments to employable people, the harsh reality is that many "truly" mentally disabled are being terminated as well. The fact that they still suffer from recurring and debilitating mental illness is apparently being routinely ignored.

An estimated 5,500 mentally disabled beneficiaries in New York State (including 2,300 in New York City) will lose benefits in federal fiscal year 1982 alone. (See Appendix I-A) This federal initiative is yet another way in which the Reagan Administration is removing the federal safety net for helpless people dependent on government benefits for survival.

The outcome of this process is all too predictable. After losing federal disability benefits, some people will apply for the public assistance program of last resort, Home Relief, further increasing state and local welfare costs. The less fortunate will end up destitute on the streets, causing yet another surge in the number of homeless people in New York City.

II. Federal social security programs for the mental disabled

To qualify for SSD and SSI disability benefits, applicants must establish their "inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." [2] Three major factors are taken into consideration: current work activity, the severity and duration of the impairment(s), and current capacity for employment.[3]

For many mentally ill New Yorkers, federal disability benefits—which average $413 a month—are the mainstay in their lives.[4] SSD and SSI are the only sources of income for thousands of chronic, mentally disabled patients discharged from State psychiatric institutions during the past two decades of deinstitutionalization. Of the 463,000 State residents receiving SSD and SSI benefits, 160,700 are mentally disabled. More than half of the mentally disabled—83,900—live in New York City.[5]

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[1] This report was prepared by Cindy Freidmutter and Audrey Hutchinson with the assistance of Barry Ensminger.

[2] "Social Security Administration Rules and Regulations," 20 CFR Subpart P, § 404.1505.

[3] Ibid., Subpart P.

[4] "Social Security Disability Bulletin," (Social Security Administration, December 1981).

[5] Telephone Interview with Lloyd Moses, Associate Commissioner, NYS Office of Disability Determination, Dec. 31, 1981.

TABLE 1.—NUMBER OF MENTALLY DISABLED FEDERAL DISABILITY RECIPIENTS IN NEW YORK STATE AND CITY

[Rounded to nearest hundred]

	New York State	New York City	Percentage of State total
SSD	78,300	32,800	42
SSI	82,400	51,100	62
Total	160,700	83,900	52

Source: New York State Department of Social Services.

The SSD and SSI Programs are both administered by the Social Security Administration (SSA).[6] Rules and regulations governing eligibility, procedures for evaluating applicants, and reviewing the status of current beneficiaries are promulgated by the SSA. The federal government contracts with the states, however, to actually perform the initial eligibility determinations and status reviews. In New York State, the Department of Social Services (DSS) performs these functions.

III. Federal disability benefits are being terminated for thousands of mentally ill beneficiaries in New York

The Social Security Act was amended by Congress in 1980 to require periodic reviews of all SSD beneficiaries at least once every three years.[7] Previously, eligibility reviews were conducted only when a mental disability was expected to improve, not for chronic psychiatric conditions. As a result of the 1980 amendment, the number of SSD reviews is expected to rise dramatically from 160,000 nationwide in 1981 to 360,000 in 1982.[8]

SSI recipients are now being reviewed in cases where mental illness is considered temporary. However, the Social Security Administration has the authority to institute periodic reviews for all mentally disabled SSI recipients as well, and is expected to do so beginning late 1983 or 1984.[9]

The accelerated review process is well underway in New York State. In the last six months of 1981, reviews of SSD cases increased by 39 percent over the same period in 1980.[10] And the Social Security Administration has an ambitious schedule for the future: reviews are expected to soar by more than 500 percent from 1980 to 1984—from 16,000 to 88,000 annually.[11]

At the same time, denial rates are going up as more and more disabled beneficiaries are losing benefits after their case review. In 1981, the proportion of SSD case closings after review rose by nineteen percent over 1980.[12] Similarly, the rate of SSI case closings increased by 22 percent from 1980 to 1981.[13]

What will these people do when their basic life support income is terminated? Many will turn to the public assistance program of last resort—Home Relief; others will join the tens of thousands of homeless men and women wandering the streets or sleeping in City shelters each night. In 1982, an estimated $28 million in federal SSD benefits will be lost statewide ($12 million in New York City alone). (See Appendix I-B). If only half of these troubled people go onto Home Relief, it will cost New York State $3.5 million annually, New York City $1.5 million and other localities $2 million, just to support the mentally ill abandoned by the federal government. (See Appendix I-C). Moreover, additional shelters will have to be opened for the homeless.

Mr. Robert Trobe, Deputy Administrator for Family and Adult Services in the Human Resources Administration, aptly summarized the impending problems for

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[6] SSD benefits are paid to disabled individuals who have contributed to the social security system for the required number of quarters. SSI benefits, on the other hand, are not based on contributions to the social security fund but are paid from general tax revenues to the financially destitute.

[7] Public Law 96-265 (June 9, 1980).

[8] Wall Street Journal (December 1981).

[9] Telephone interview with Lloyd Moses, associate commissioner, NYS Office of Disability Determination.

[10] Telephone interview with Helene Ebenstein, coordinator, New York Regional Office of the Social Security Administration, on Dec. 23, 29, 30, 1981. Also see Table 2.

[11] Telephone interview with Lloyd Moses. See footnote 9.

[12] Telephone interview with Helene Ebenstein. See table 2.

[13] Ibid., Also see table 4.

New York City: "This federal initiative can only mean added costs to New York City. When federal disability benefits are terminated, the mentally ill will inevitably turn to home relief or the City's shelters. This additional burden could not be coming at a worse time." [14]

TABLE 2.—SSD REVIEWS IN NEW YORK STATE, 1980–1981

	Period		Percent increase
	May 2, 1980 to Dec. 26, 1980	May 1, 1981 to Dec. 4, 1981	
Number of cases reviewed	7,597	12,440	39
Number of denials	2,808	5,437	49
Percentage of denials	37	44	19

Source: New York regional office of the Social Security Administration.

TABLE 3.—*Five year schedule for SSD reviews in New York State*

Fiscal year:	*Number of reviews*
1980	16,000
1981	20,000
1982	38,000
1983	63,000
1984	88,000

Source: New York State Department of Social Services.

TABLE 4.—SSI REVIEWS IN NEW YORK STATE, 1980–1981

	Period		Percent increase
	May 2, 1980 to Dec. 26, 1980	May 1, 1981 to Dec. 4, 1981	
Number of cases reviewed	6,049	5,545	(−11)
Number of denials	2,690	3,017	12
Percentage of denials	44	54	22.7

Source: New York regional office of the Social Security Administration.

IV. In many cases, reviewers are abusing their authority and terminating the "truly" mentally disabled

At a time when the Social Security system is experiencing major financial difficulties and public funds for social programs are in short supply, no one can argue with the need to maintain strict procedures to insure that disability benefits are not provided to mentally competent people who are able to work. However, it appears that many clearly eligible, mentally disabled beneficiaries are being terminated after case reviews.

In assessing whether someone has the mental capacity to work, reviewers are legally required to "consider factors such as [the] ability to understand, to carry out and remember instructions, and to respond appropriately to supervision, co-workers and work pressures in a work setting."[15] After a series of interviews with mental health professionals and legal services lawyers, it appears these factors are routinely being ignored.[16] For the mentally ill, the consequences can be devasting.

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[14] Telephone interview with Robert Trobe, Deputy Administrator for Family and Adult Services of the Human Resources Administration, on Jan. 19, 1982.

[15] "Social Security Administration Rules and Regulations," 20 CFR, Subpart P, §416. 945(c).

[16] Mental health professionals in seven agencies serving the chronically mentally ill were surveyed—Transitional Services, The Bridge, the St. Francis Residence, the Washington Heights-Inwood Community Mental Health Center, the Soundview Throgs Neck Community Mental Health Center, South Beach Psychiatric Center and Kings County Hospital. Attorneys representing the mentally disabled from Lawyers for the Public Interest and Legal Services for the

Continued

Harry Baird[17] *of the St. Francis Residence*[18].—Forty year old Harry Baird is both mentally and physically disabled. Prior to 1973, he had been hospitalized at least once a year for two to three week periods. He has been known to the St. Francis priests since 1973, when he was released from the Manhattan State Psychiatric Hospital. Mr. Baird is diagnosed as suffering from chronic schizophrenia.

Since he became affiliated with the St. Francis program, his mental condition has somewhat stabilized. He has been hospitalized only three times since 1973, the most recent in November, 1980. With the aid of the St. Francis escort service, he regularly attends a state psychiatric clinic, and he receives medication daily at the residence.

In the summer of 1981, Mr. Baird was hospitalized at Bellevue with chest pains and high blood pressure. Doctors found that his heart was enlarged to the size of a football; his prognosis was described as very poor.

In August, 1981, Mr. Baird received notification that his SSD eligibility was being reevaluated, and that he had to appear on two separate occasions for physical and psychiatric examinations. Despite his appearances, Mr. Baird received in September a letter of termination, which he appealed with the help of the St. Francis staff.

Questioning the reasonableness of the decision that Mr. Baird was "employable", St. Francis social worker John Gaines described his client's limited capacity to perform even simple tasks: "When you speak to this man, he simply doesn't understand what you are talking about. He often doesn't respond. We have to watch him take his medication to make sure he doesn't take the wrong thing at the wrong time. He could not even get to an appointment at the Social Security office on his own. He must always have an escort."[19]

Dr. Charles Rosenbloom, his treating psychiatrist, also questioned the decision.

"[Mr. Baird] suffers from chronic auditory and visual hallucinations, including command hallucinations of a suicidal nature; the patient has acted on these command hallucinations on more than one occasion in the past. These symptoms do not disappear with the psychotropic drugs which he receives at the clinic.

"[He] has the fragile ego structure of a chronic schizophrenic. He is unable to cope with the stress of everyday life without the constant support of the on-site staff at his residence and the interventions of this clinic. He is a fearful, isolated individual who is totally dependent upon the social structure provided by the residence. He has been referred to Day Programs on several occasions in the past, but these experiences have proved to be so threatening that his symptoms increased to an alarming degree (particularly in view of his suicidal attempts,) and the programs were discontinued.

"Since [Mr. Baird] is unable to relate in the relatively safe environment provided by a therapeutic day program it is impossible to consider him as a candidate for employment. His prognosis remains extremely guarded and his ability to assume competitive employment, even at a most basic level, is non-existent. There is no time in the foreseeable future that this prognosis will improve based on our observations of his capacity to cope since he began treatment with us in 1973.

"We hope that you understand the seriousness and indeed life threatening nature of [Mr. Baird's] disability and will reinstate him on the disability rolls."[20]

In November, Mr. Baird received a final notice that benefits were being terminated. The letter stated that, while he might not be able to resume his previous occupation (he had been a cart-pusher in the garment district), he could perform some kind of work.

With the assistance of the St. Francis staff, Mr. Baird filed a final appeal and is now waiting for a hearing to be scheduled.

The church has deferred Mr. Baird's rent and is loaning him money for food and other expenses. Priests at St. Francis state that if he were on his own he would never be able to pursue the appeal. He cannot read and hands his correspondence

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Elderly Poor were interviewed as well. Together, these professionals provided information on dozens of disability recipients whose eligibility status was recently reviewed. In the opinion of the health professionals surveyed for the report, none of the individuals terminated from the federal disability rolls were "employable" in any realistic sense. (See appendix II for the names and titles of mental health professionals and legal services lawyers interviewed for this report.)

[17] All names of disability recipients used in this report are pseudonyms.

[18] Telephone Interview with Al Pettis, program director, St. Francis Residence, on Dec. 29, 1981, Jan. 5 and 6, 1982.

[19] Telephone interview with John Gaines, social worker, St. Francis Residence, on Jan. 15, 1982.

[20] Letter from Dr. Charles Rosenbloom, to the Office of Disability Determination, dated Oct. 14, 1981.

unopened to the St. Francis workers. They believe he is not really aware of his situation.

Alan Palmer of South Beach State Psychiatric Hospital.[21]—After his SSI benefits were terminated, Alan Palmer threatened to assassinate President Reagan and was admitted to South Beach State Psychiatric Hospital as a result. Thus, just days after being notified by the Department of Social Services that he was "employable", psychiatrists were hospitalizing Mr. Palmer as delusional and a danger to others.

Linda Breslin, Deputy Director of South Beach, emphasized that he "could maintain himself out of the hospital but could never work. The stress of having his livelihood cut off led to the last hospitalization and rather drastic threat."[22]

Jane Rollen of Washington Heights CMHC.[23]—Jane Rollen is a 46 year old woman, living at the Washington Heights-Inwood residence since January 1981. Previously, she was homeless and slept on the streets of Manhattan.

In 1967, Ms. Rollen began receiving SSD and SSI disability benefits (after she became delusional and was diagnosed as suffering from chronic schizophrenia). Since then, she has undergone several psychiatric hospitalizations, the most recent in the spring of 1980. Ms. Rollen also suffers from severe back pain as a result of a previous injury. She attributes the back pain to possession by demons.

In November 1981, Ms. Rollen was notified that her disability benefits would be terminated because she was determined to be "employable". With the help of her counselors, she is now appealing that decision.

John Gables of The Bridge.[24]—Mr. Gables is 46 years old and has a ten year history of manic-depressive psychosis. He has experienced twelve manic episodes requiring hospitalization, the most recent in August, 1981. Divorced when he became ill, Mr. Gables has lost all contact with his former wife and two children. With the support of the Bridge Social Rehabilitation Program, which he has attended daily for the past two years, he is able to live on his own. He is also seen regularly at St. Luke's Psychiatric Outpatient Clinic and takes lithium to control his symptoms.

His last full-time job was in 1973. In 1977, Mr. Gables enrolled in an Office of Vocation Rehabilitation training program but was forced to drop out after a month because it was too stressful. In 1980 he tried to work as a census taker, but again work proved too stressful and he was rehospitalized.

In September, 1981, Mr. Gables was asked to submit evidence to support his claim of psychiatric disability. Despite the fact that all professional staff members at the Bridge sent letters stating that Mr. Gables was unemployable, his claim was turned down.

Jane Michele, Director of the Bridge's Day Program commented on the DSS decision. "Mr. Gables is motivated to work as indicated by his history and he has attempted to return to work, but he manifests severe depression which makes it very difficult for him to function. He also has periods when he is really manic. He has difficulty sleeping then and often becomes delusional. He is also very hyperactive. His case is really sad because he would really like to work, but his illness prevents him."

Mr. Gables had his hearing on January 19, 1982. Ms. Michele says that the stress was too much for him and he will probably need to be rehospitalized.

Sadly, Harry Baird, Alan Palmer, Jane Rollen and John Gables do not seem to be isolated and atypical examples of mentally disabled people now being terminated from the Social Security Disability rolls.

Many psychiatrists and social workers interviewed for this report expressed anger at the termination of benefits for vulnerable men and women under their care. Dr. Itamar Salaman, Director of the Soundview-Throgs Neck Community Mental Health Center, echoed the feelings of many of his colleagues in his criticism: "The disallowance of disability coverage appears to be an arbitrary, unfeeling and unthinking procedure causing great distress to large numbers of very chronically and seriously ill psychiatric patients and their families. It is only with great effort and much support that these people are able to remain outside of hospitals. The ultimate outcome of this inhumane policy will be to add to the numbers of homeless and to increase the psychiatric readmission rate to hospitals, thus shifting the financial burden for caring for these helpless people to the cities and states. The cost of hospitalization is far greater than keeping them in community-based programs."[25]

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[21] Telephone interview with Linda Breslin, Deputy Director of Treatment Services, South Beach Psychiatric Center on Jan. 18, 1982.

[22] Ibid.

[23] Telephone interview with Pam Pennell, senior residence counselor, Washington Heights-West Harlem Inwood Mental Health Council, on Dec. 22, 1981, and Jan. 5, 1982.

[24] Telephone interview with Jane Michele, director of day program, The Bridge, Inc., on Dec. 29, 1981, and Jan. 13. 1982.

Ms. Margaret Murphy, Human Resources coordinator for Transitional Services, a mental health program for the chronically ill located in Queens, said that the number of terminations of seriously ill program participants had increased dramatically. Between August and December, 1981, she accompanied 18 clients to disability hearings after their benefits were terminated, compared to one hearing every three months previously. She reported that all 18 clients were chronically disabled with long-term, serious and extensive psychiatric problems:

"I have been with clients on occasions when they were experiencing psychotic episodes at the hearings, and the hearing officer still upheld the denial of benefits.

"The slightest progress evidenced by our clients was used as the justification to terminate benefits at a time when these men and women were clearly not ready for completely independent living. Loss of income at that stage wiped out years of progress by triggering a relapse or causing the client to leave the program prematurely."[26]

Dr. Ginny Gerbino, attending psychiatrist at Kings County Hospital, has treated many patients after SSD benefits were terminated:

"Despite the fact that mentally disabled patients are out of the hospital, they are often not employable. These people, who are most in need of what public assistance benefits have to offer, are rendered helpless when benefits are cut off precipitously. It is tantamount to punishing these patients for the progress they have made in staying out of the hospital.

"One of the great misunderstandings of this particular problem is that progress made in remaining out of the institution and adjusting to living in the community is the same as employability. It is not."[27]

When questioned about the impact of the eligibility reviews on his patients, Dr. Roger Brunswick, Medical Director of the Bridge, said:

"Chronic psychiatry patients live in a very precarious state of mental health. Predictability in their lives leads to the least amount of stress and results in a dramatic decrease in psychotic episodes and hospitalizations. Most of them have tried to work in the past and have not been able to tolerate even the stress of the easiest jobs.

"Cutting off the disability benefits of chronic mental patients is to cut off one of the only constant things in their lives and, as it would be for anyone, it is a major stress. We have seen at the Bridge, a number of psychotic decompensations and hospitalizations as a result of the discontinuation of benefits. In people who have already shown their difficulty in competing in the world of work, cutting off their only financial support is a catastrophe."[28]

The federal disability recipients discussed here are all involved in mental health programs which have provided support and advocacy for their patients undergoing review. They have also given financial support when benefits were terminated. Yet, due to New York City's inadequate community mental health system, only a fraction of the chronically mentally disturbed population have access to such services.[29]

Mentally disabled SSD and SSI beneficiaries not receiving services from a mental health or social service agency are even more likely to lose benefits; not because they are more "employable", but because they are unable to effectively cope with the bureaucratic process.

Mr. Robert Hayes, the attorney for homeless plaintiffs in *Callahan* v. *Carey*,[30] is alarmed by the threat to the economic stability of SRO and adult home residents:

"Many of these poor disabled people simply cannot negotiate the bureaucratic maze by themselves. With recent cutbacks in legal services programs, they'll go unrepresented. When their checks stop, they lose their place to live. That is how people become homeless."[31]

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[25] Telephone interview with Dr. Itamar Salaman, director, Soundview-Throgs Neck Community Mental Health Center, on Jan. 6, 1982.

[26] Telephone interview with Margaret Murphy, human resources coordinator, Transitional Services, on Dec. 29 and 30, 1981, and Jan. 5 and 6, 1982.

[27] Telephone interview with Ginny Gerbino, M.D., attending psychiatrist, Kings County Hospital, on Jan. 7, 1982.

[28] Telephone interview with Roger Brunswick, M.D., medical director, The Bridge, Inc., on Jan. 8, 1982.

[29] In New York City, only 6 percent of the chronically mentally ill are receiving case management social services, and 22 percent are receiving needed clinical treatment. (Source: New York State Office of Mental Health 1981, 5-year plan.)

[30] Supreme Court, N.Y. County, Index No. 42582-79

[31] Telephone interview with Robert Hayes, staff attorney for the Coalition for the Homeless, on Jan. 12, 1982.

V. *Complying with complex review procedures is often difficult for confused mentally ill beneficiaries.*[32]

Federal disabililty benefits can, and often are, terminated even before a formal case review on the merits takes place. Under federal law, the responsibility to submit all evidence required for review rests with the beneficiary. Failure to supply this information is ground for termination.

Placing this responsibility on mentally ill men and women is obviously problematic. A three page questionnaire is attached to the notice of review which must be completed and returned. (See appendix IV). Medical evidence is required to document the beneficiary's claim of mental disability. Even if the questionnaire is returned and medical evidence provided, the Department of Social Services may require the beneficiary to show up and submit to a medical and/or psychiatric examination.[33]

This process is difficult enough to negotiate when the mentaly ill have social workers advocating on their behalf. For sick people without any direct contact with a mental health program, it can be impossible. The Department of Social Services purports to deal with this problem by referring all cases (where the mentally disabled do not respond to two notices) to SSA district offices for a home visit.

In fact, it does not appear that Social Security offices are personally assisting all mentally disabled beneficiaries who need help, although the dimensions of the problem are unclear. Ms. May Blatt, Director of the New York City Regional Office of the DSS Office of Disability Determinations, could not provide any figures on the numbers of cases already referred for home visits. In another attempt to understand the actual availability of home visits, we directly contacted intake workers at the Social Security Administration and Department of Social Services.

Three workers at the central information number for Social Security were telephoned; each stated that mentally disabled beneficiaries receiving checks directly were considered to be "competent" and were automatically terminated if they didn't reply to the review notices. Local Social Security offices in Brooklyn, Queens and Manhattan were also contacted. Intake workers in these offices stated that the DSS Office of Disability Determinations did forward requests for home visits for some mentally disabled beneficiaries under review, but could not say whether this occurred in all cases. When the Division of Disability Determination was telephoned again, we were told that home visits could be requested but that the decision was discretionary and not done in every case.

Even with proper assistance, the mentally ill often have trouble representing themselves during the review process. A social worker at Transitional Services, Joseph Berkman, says that patients generally approach the hearings with "intense feelings of anxiety. In some cases, they become emotionally paralyzed when confronted with it."[34]

Problems were also found with the psychiatric examinations conducted by DSS for benficiaries that did manage to complete and return the initial questionnaire. DSS requires that a thorough mental status examination and complete medical history be done.[35] The reality, however, can be quite different.

One chronic patient at the Soundview-Throgs Neck Community Mental Health Center was recently taken off thorizine because of her adverse reaction to the medication and given valium to minimize her disruptive behavior. According to the patient, who is considered reliable by her social worker, the examination consisted of the following:

M.D. Hello.

PATIENT. Hello.

M.D. What kind of medication are you on?

PATIENT. I'm on Valium.

M.D. Oh . . . you are on Valium. You are not sick![36]

The father of a South Beach Psychiatric Center Outpatient timed the length of his son's examination—it lasted four minutes. Ms. May Blatt admitted that it is impossible to do the kind of work-up required by the agency in that limited time period.

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[32] Appendix III describes the various stages of the review process.

[33] Interview with May Blatt, director of the New York City regional office of the Office of Disability Determination.

[34] Telephone interview with Joseph Berkman, social worker, Transitional Services, on Jan. 12, 1982.

[35] Telephone interview with May Blatt. See Footnote 33.

[36] Telephone interview with Catherine Meany, clinical coordinator, Adult Outpatient Clinic, Soundview-Throgs Neck Community Mental Health Center, on Jan. 13, 1982.

Formal appeals are available after an unfavorable review decision, but effective representation is even more important at this stage. Unfortunately, many mentally disabled beneficiaries lack this assistance as well. According to Linda Breslin, the Deputy Director at South Beach State Psychiatric Hospital:

"It appears to us that many more patients are categorically being denied SSD and SSI benefits and are not being recertified. We are often able, however, to reverse the final denial of benefits for our patients during the appeals stage. It is State Office of Mental Health policy to appeal to all of these cases.

"This requires an enormous amount of time and work. Our clients do not have the resources to hire or locate attorneys, nor can they understand the complications and intricacies of the appeals process.

"It is highly unlikely that confused and disorganized individuals who do not have the support of a skilled professional working on their behalf could negotiate the appeals system."[37]

The large numbers of the mentally disabled forced to confront this process on their own may, because of their inability to comply with the review requirements, lose their benefits without ever having a fair review of the merits of their claim. Without personal assistance by DSS and SSA at every stage of the process, many "truly" disabled men and women will loss their only source of support and be forced into the shelters and onto the streets.

DSS officials concede that they have not been given the financial resources to provide effective personal assistance to the mentally disabled who need it.[38] The SSA has raised the number of eligibility reviews for New York State, but it has not increased DSS's budget accordingly, making it difficult for DSS to adequately review each case. From 1981 to 1982, the number of scheduled reviews is projected to increase by 53 percent while DSS's budget has been raised by only about 2.5 percent in real dollars.[39]

With all these apparent difficulties, the burden is on the Social Security Administration and Department of Social Services to demonstrate that the review process is procedurally fair to the mentally disabled. Requests for more detailed information have been sent to SSA and DSS to enable more comprehensive analysis by the City Council President's Office. (See appendix V).

VI. Conclusion and recommendations

Beginning in 1980, Congress required periodic case reviews of all mentally disabled social security beneficiaries. The legislative purpose was laudatory: to assure that all federal disability beneficiaries are, if fact, unemployable due to their mental or physical impairment. Unfortunately, this laudatory purpose is being undermined by improper implementation. Placing the burden of proof on mentally disabled beneficiaries is a serious injustice to the many beneficiaries too ill to represent themselves. Without adequate assistance, confused and disturbed people are being terminated for failure to cooperate before a review on the merits even takes place. In other instances, beneficiaries with severe impairments are deemed "employable" despite strong pyschiatric evidence to the contrary.

The State Department of Social Services has already agreed to cooperate with the Council President's ongoing investigation of this problem. Further analysis will be developed in the coming months as additional information is provided. In the meantime, it is clear that a number of steps must be taken immediately:

1. Social Security Disability benefits for mentally disabled beneficiaries should not be terminated prior to a case review on the merits. Failure to respond to written notices, complete the questionnaire, provide medical documentation, or show up for a psychiatric consultation cannot be the basis for automatic termination of benefits to chronically mentally ill people.
2. Mentally disabled beneficiaries must be provided with personal assistance (and home visits if necessary) throughout the review process. Legal representation should be provided for appeals after the initial case review. The Department of Social Services should consider contracting with the private bar or legal services attorneys with experience in social security disability hearings to provide the necessary legal assistance to beneficiaries.
3. Psychiatric social workers and psychiatrists working in community mental health programs should be given training in what type of information is required by the Social Security Administration to verify mental disability.

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[37] Telephone interview with Linda Breslin. See footnote 21.

[38] Telephone interview with Lloyd Moses and May Blatt. See footnotes 9 and 33.

[39] Telephone interview with Lloyd Moses. See footnote 9.

4. The Department of Social Services should begin a study of the impact of terminating federal disability benefits on rehospitalization rates, the mental health of beneficiaries, home relief rolls, and City shelters for the homeless.

5. The Congress should schedule hearings on the implementation of the 1980 amendment, its fiscal impact on state and local government, and the appropriateness of placing the burden of proving continued disability on mentally impaired beneficiaries.

APPENDIX I

A. Number of Mentally Disabled SSD Recipients Estimated to Lose Benefits in FY 1982*

38,000	Projected NYS SSD recipients reviewed in FY 1982
÷ 3	1/3 SSD recipients are mentally disabled
12,666	Estimated DSS reviews of mentally disabled recipients in FY 1982**
x 44%	Termination rate***
5,573	Estimated number of NYS mentally disabled losing benefits in 1982
x 42%	Percentage of SSD population living in NYC
2,340	Estimated number of NYC mentally disabled losing benefits in FY 1982

B. Amount of Federal SSD Funds Lost to the Mentally Disabled in New York State and New York City in FY 1982

5,573	Estimated number of NYS mentally disabled SSD recipients losing benefits in FY 1982
x $4,956	Average annual SSD benefit
$27,619,788	Estimated amount of federal SSD benefits to mentally disabled lost in New York State in FY 1982
x 42%	Percentage of SSD population living in NYC
$11,600,310	Estimated amount of federal SSD benefits to the mentally disabled lost in NYC in FY 1982

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* FY 1982 refers to the federal fiscal year -- October 1, 1981 to September 30, 1982

** This is a conservative figure. DSS and SSA officials indicate that more of the mentally disabled will be targeted for review in FY 1982 and early FY 1983

*** It is assumed that the termination rate will remain at FY 1981 levels

C. Home Relief Costs to NYS and NYC

5,573	Estimated number of NYS mentally disabled SSD recipients losing benefits in FY 1982
x 50%	Apply and receive home relief*
2,786	Estimated number of former SSD recipients added to home relief rolls
x $2,535	Average annual statewide home relief benefit **
$7,063,777	Total increased New York State home relief cost

Cost to State: $3,531,889

Cost to City: $1,483,393

Cost to Other Localities: $2,048,496

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* For the purposes of this analysis, it is assumed that half of the terminated mentally disabled federal recipients will both apply for and receive home relief.

** This figure represents the average state home relief payment in 1980, with 8% added for the 1981 home energy allowance.

APPENDIX II

INTERVIEWS WITH MENTAL HEALTH PROFESSIONALS AND LEGAL ADVOCATES

1. Shirley Abel, Director of Clinical and Rehabilitation Services, Altro Health and Rehabilitation Services.
2. Joseph Berkman, Director, Community Residence—Phase II, Transitional Services.
3. Roger Brunswick, M.D., Medical Director, The Bridge, Inc.
4. Tim Casey, Welfare Coordinator, Community Action Legal Services.
5. Juanita Carillo, Assistant Director of Crisis Intervention for Special Housing Services, Human Resources Administration.
6. Assemblyman Daniel Feldman, 45th Assembly District, Brooklyn.
7. Jim Finley, Intergovernmental Liaison, National Association of State Mental Health Directors.
8. Ginny Gerbino, M.D., Attending Physician, Kings County Hospital.
9. Lewis Golinker, Staff Attorney, New York Lawyers for Public Interest.
10. Tobi Golick, Attorney, Legal Services for the Elderly Poor.
11. Pat Harding, Director, Manhattan State Psychiatric Hospital After Care Clinic.
12. Dan Herman, Program Director, Community Residence Program, Bowery Residence Committee.
13. Delores Lannie, Member, Project Release.
14. Father John McVean, St. Francis Residence.
15. Catherine Meany, Clinical Coordinator, Adult Outpatient Clinic, Soundview-Throgs Neck Community Mental Health Center.
16. Jane Michele, Director of Day Program, The Bridge, Inc.
17. Margaret Murphy, Human Services Coordinator, Transitional Services.
18. Mr. Newman, Partner, Simon, Newman and Brook.
19. Pam Pannell, Senior Residence Counselor, Washington Heights, Inwood West Harlem Mental Health Council.
20. Regina Pergerski, Director of Social Work, South Beach Psychiatric Hospital.
21. Al Pettis, Program Director, St. Francis Residence.
22. Barry Roff, M.D., Assistant Director of Clinical and Rehabilitation Services, Altro Health and Rehabilitation Services.
23. Itamar Salaman, M.D., Director, Soundview-Throgs Neck Community Mental Health Center.
24. Gene Sofonoff, Assistant, Office of Assemblyman Daniel Feldman, 45th Assembly District.
25. Majorie Stuckle, Social Worker, Soundview-Throgs Neck Community Mental Health Center.
26. Michael Trambetta, former Social Security recipient and member of Project Release.
27. Lilliam Turin, Senior Caseworker, Altro Health and Rehabilitation Services.
28. Carol Viani, Program Supervisor, SRO Program, Human Resources Administration.
29. Jane Yohalem, Staff Attorney. Mental Health Law Project.
30. Linda Breslin, Deputy Director of Treatment Services, South Beach State Psychiatric Center.
31. Robert Hayes, Attorney, Coalition for the Homeless.
32. Robert Jorgen, Director, Crisis Intervention Services of the Human Resources Administration.
33. Robert Trobe, Deputy Administrator, Family and Adult Services of the Human Resources Administration.

APPENDIX III

DISABILITY REVIEW PROCESS FOR SSA AND SSI RECIPIENTS

1. Beneficiary is notified of the eligibility review by the SSA and must complete and return a three page questionnaire to the Office of Disability Determination (ODD). If the beneficiary does not respond to written notices within 30 days, benefits may be terminated. If the beneficiary does respond, a preliminary decision of eligibility is made by State.
2. If the preliminary decision is to terminate benefits, SSD and SSI recipients have 10 days to notify the ODD of their interest in submitting additional evidence and 60 days to submit the information.

3. An initial determination is made by ODD. If the decision is to terminate benefits, SSD recipients have 60 days to request a reconsideration of the decision. On the other hand, if an SSI claimant is denied benefits, there is no reconsideration stage—the process goes immediately to a hearing.

4. A hearing before an Administrative Law Judge (ALJ) can be requested within 60 days if the SSD claimant is dissatisfied with the reconsideration decision. Further benefits to SSD recipients terminate at this stage. SSI recipients, on the other hand, continue to receive aid pending appeal.

5. If the claimant is dissatisfied with the ALJ decision, then an appeal can be made to the Appeals Review Council of SSA within 60 days of the decision.

6. If the claimant is dissatisfied with the SSA's final decision, an action may be filed in federal district court within 60 days.

Source: May Blatt, director of the New York City regional office of the New York State Department of Social Services, Office of Disability Determinations.

SSA-454a Social Security Disability Beneficiary Report
Reference: DI 1109, 2810, 2840, 2860, 2861, 2862, 2864, 2868

Refer to
Social Security Number Date

When your disability payments began, you were notified that your condition might improve and your claim was scheduled for a future review. The Social Security Administration has requested us to develop current evidence as to whether your condition still prevents you from working.

To help us determine whether you are still entitled to disability (or blindness) benefits, please answer the questions on the next three pages, sign your name at the bottom, and return the form promptly. Use the enclosed envelope which requires no postage.

Pursuant to the Privacy Act of 1974, you are advised that 42 U.S.C. 421(a) authorizes the Social Security Administration to collect the personal information requested on this form to decide if you are still disabled. Your response is optional. However, if you do not provide the required information, a decision based on the evidence in your file can result in a determination that continuing eligibility for payments may cease.

The information you furnish on this form may be disclosed by SSA to another person or to another government agency for the following purposes:

1) to assist SSA in establishing the right of an individual to social security or black lung benefits and/or the amount thereof;
2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the programs administered by SSA; and
3) to comply with Federal laws requiring the exchange of information between SSA and another agency (such as the General Accounting Office).

If at any time medical evidence shows that your condition has improved so much that you are no longer disabled (or blind), you will still receive benefits for a 3-month period of adjustment. This period includes the month in which your condition improved and 2 additional months. Benefits will then be stopped.

If you have questions, or need help in filling out the questionnaire, please telephone or visit any social security office. The people there will be happy to help you. You can find the telephone number and address in the telephone directory under "Social Security Administration," or you can ask at your local post office. If you visit the social security office, please bring this letter with you.

Enclosure:
Pre-Addressed Envelope

FORM SSA-454a (3-77)

SSA-454a (Con't)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF DISABILITY INSURANCE

Form Approved
OMB No. 72-R0910

SOCIAL SECURITY DISABLED PERSON REPORT

No further monies or other benefits may be paid out under this program unless this report is completed and filed as required by existing public law 89-97

I understand that this report will be used to determine whether to continue or to stop my disability case benefits. I also understand that if I am receiving social security disability benefits and supplemental security income payments, this questionnaire is applicable to both claims.

INSTRUCTIONS FOR COMPLETING THE FORM

Answer each question as fully as possible.

If any question does not apply to you, write "none" in the space provided

If you need more space to answer a question, use the back of this form or a separate sheet of paper, If you use a separate sheet of paper, please be sure to put your social security claim number on it.

Answer all parts of the following questions:

1. (a) Do you feel your medical condition has improved so that you are able to return to work?

☐ Yes ☐ No If No, explain below.

(b) Has your doctor told you that you are able to return to work?

☐ He said Yes If the answer is yes, when?__________________*(give date)*

☐ He said No ☐ He did not say

(c) Has he placed any significant restrictions on the kind of work you may do or how many hours a day you may work?

☐ No ☐ Yes If Yes, explain below

Describe below in your own words your present condition: be sure to list what you are unable to do in terms of standing, walking, bending or any other activity that interferes with your working.

SSA-454a (Con't)

2. Give name, address and telephone number of your physician(s) and of the hospital or clinic where you have received treatment for the condition since you became entitled to benefits.

(a) NAME OF PHYSICIAN, HOSPITAL OR CLINIC	DATE LAST TREATED
ADDRESS	TELEPHONE NUMBER
(b) NAME OF PHYSICIAN, HOSPITAL OR CLINIC	DATE LAST TREATED
ADDRESS	TELEPHONE NUMBER
(c) NAME OF PHYSICIAN, HOSPITAL OR CLINIC	DATE LAST TREATED
ADDRESS	TELEPHONE NUMBER

3. Have you worked in the past 12 months?

☐ No ☐ Yes *If "Yes," be sure to complete all of the following items.*

(a) NAME, ADDRESS AND TELEPHONE NUMBER OF EMPLOYER			(b) KIND OF WORK DONE	
(c) WHEN STARTED *(Date)*	(d) AVERAGE HOURS WORKED		(e) AVG. GROSS EARNINGS *(Before payroll deduct.)*	
	PER DAY	PER WEEK	PER DAY	PER WEEK

(f) ARE YOU STILL WORKING?

☐ Yes ☐ No *If "No," explain below why and give date you stopped working.*

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4. (a) Are you receiving services, training or counseling from or through the State vocational rehabilitation agency?

☐ No ☐ Yes *If "Yes," answer question (b)*

(b) Name and address of servicing rehabilitation office and counselor.

5. Remarks: Enter here any additional information that you believe is important and will assist in the review of your continuing entitlement to social security disability benefits. *(If you need more space, use a separate sheet of paper. Also, if you wish, you may attach any evidence that shows your current condition.)*

6. Do you authorize any physician, hospital, agency, or other organization to disclose to the Social Security Administration or to the State agency that may review your entitlement for continuing disability benefits, any medical records or other information about your disability?

☐ Yes ☐ No

I certify that the above statements are true, correct, and complete to the best of my knowledge. I know that anyone who fraudulently conceals or fails to report a disqualifying event or who makes a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act could be subject to a fine or imprisonment or both.

SIGN YOUR NAME AS YOU USUALLY WRITE IT	DATE	PHONE NUMBER

If the address shown on page one of this form is incorrect or incomplete please enter your present address below

NUMBER AND STREET, APARTMENT NO., P.O. BOX, OR RURAL ROUTE

CITY	STATE	ZIP CODE

☆U.S. GOVERNMENT PRINTING OFFICE: 1977—260-957/45

APPENDIX V

THE CITY OF NEW YORK,
THE PRESIDENT OF THE COUNCIL, CITY HALL,
New York, N.Y., January 21, 1982.

Hon. BARBARA B. BLUM,
Commissioner, Department of Social Services,
2 World Trade Center, New York, N.Y.

DEAR COMMISSIONER BLUM: Last month, I received a number of complaints from mental health agencies regarding the marked increase in eligibility reviews of mentally disabled social security beneficiaries. In their opinion, a large number of seriously ill and unemployable mentally disabled people are being terminated from the social security rolls as a result of these reviews.

For the past several weeks, my staff has investigated these complaints and has uncovered what appears to be serious problems with the eligibility reviews conducted by the Division of Disability Determination, pursuant to federal guidelines. These findings are contained in the enclosed copy of my staff report, "Passing the Buck: Federal Efforts to Abandon the Mentally Disabled."

Mental health professionals and lawyers representing the mentally disabled have provided my office with numerous case studies documenting various problems with the review process. Unfortunately, the Division of Disability Determination could not provide the necessary data to assess the full dimensions of these problems. When we talked yesterday, you indicated a willingness to work with my office and to institute administrative reforms where necessary. The following information would be extremely helpful in this joint effort.

1. The numbers of mentally disabled Social Security Disability recipients in New York State and City:
   (a) identified by the Social Security Administration for review in calendar year 1981.
   (b) failing to respond to one or more written notices of review;
   (c) returning compiled questionnaires;
   (d) terminated for failure to cooperate;
   (e) referred by DSS to local social security offices for a home visit;
   (f) receiving home visits;
   (g) referred for a consultative examination;
   (h) terminated after a case review;
   (i) requesting reconsideration of the initial review determination;
   (j) restored to the rolls after reconsideration;
   (k) requesting a formal hearing before an Administrative Law Judge;
   (l) restored to the rolls as a result of a hearing decision by an Administrative Law Judge;
   (m) applying for home relief, sleeping in City shelters, or admitted to State psychiatric hospitals;
2. A list of physicians, with their addresses and telephone numbers, used by the New York City Regional DSS Office of Disability Determination to perform consultative examinations on the mentally disabled.
3. All written instructions, and examination forms provided to physicians performing consultative psychiatric examinations.
4. All relevant regulations, written criteria, Social Security directives, and sections of the SSA operations and procedures manuals used by the Office of Disability Determination to review the continued eligibility of mentally disabled beneficiaries.
5. The number of review decisions to continue benefits which were reversed by the Social Security Administration in 1981.

I appreciate your cooperation in providing this detailed information to my office. Please contact my Counsel, Cindy Friedmutter, in the event that clarification or discussion is needed for any of the requested information. She can be reached at (212) 566-6896.

I look forward to working with you on this important issue.

Sincerely,

CAROL BELLAMY, *President.*

LAW OFFICES OF SCHEINE, FUSCO & BRANDENSTEIN, P.C.,
New York, N.Y., March 24, 1982.

John J. Salmon, Esq.,
Chief Counsel, Committee on Ways and Means, Washington, D.C.

DEAR MR. SALMON: From the vantage point of a practitioner in the field of Social Security Law since 1976, and as the President of the New York Social Security Bar Association, and a member of the National Organization of Claimant's Representatives, please allow me to submit comments regarding the Proposed Disability Amendments of 1982. Please include these comments in the Congressional Record. I will review the Bill in the order it has been presented.

1. Disability Termination Process: The present practice as outlined in the first paragraph of the materials provided, indicates that State Agencies are granting claimants approximately twenty-five (25) days to submit evidence regarding continuing disability. This has been my experience. In actuality, and the Committee notes, it is virtually impossible for an individual to obtain medical evidence within that time limitation.

The Bill proposes that a disability insurance benefits beneficiary would be given the option of having his benefits continued up to the reconsideration decision. If, however, that decision is unfavorable, the beneficiary would be required to pay the benefits back. I believe that from the beneficiary standpoint this continuation of benefits is a good idea, but from the Administration's standpoint, collecting these overpayments would be an impossible burden. It is noted later on in the Bill that very few of the terminated beneficiaries ever return to work. Where then would the Administration proposed to recoup the overpayment from?

The Bill proposes an evidentiary hearing at the State Agency level. As an attorney I am very much opposed to this development. A question arises as to who will be adjudicating the claim and what due process rights will be afforded at the State Agency level. Will the claimant have the right of confrontation? Will he be able to cross examine those who would give adverse evidence?

What type of Administrative record will be made at the State Agency level? What type of representation will claimants be afforded before the State Agency especially in view of the fact that this Bill proposes to eliminate attorney fee provisions.

I do agree with the provision regarding waiver of overpayments. It appears to be illogical and unfair to tell a claimant that as of six (6) months ago, he was no longer disabled six months after the fact. These overpayments should be waived and are being waived routinely by Administrative Law Judges on equitable grounds.

2. The Bill proposes to strengthen the reconsideration process. The Bill recognizes that at the present time, the reconsideration process is to a large extent a rubber stamp of the initial termination or initial application process. While I agree that the reconsideration process should be strengthened, (a State Agency should be compelled to do their jobs of obtaining available evidence), I do not believe the record should be closed after the reconsideration procedure.

Whatever provisions are made, it must be realized that the adjudicators at the State Agency level are not of the caliber of the Administrative Law Judges.

As an aside, the material states that "attorneys for this and other reasons are not contesting cases at reconsideration".

I think this is not entirely correct. My office always submits evidence at the reconsideration level. One of the problems with handling cases at the reconsideration level, which we will address in further detail in another section of this memorandum, is the fact that, at the reconsideration level, the counsel fees are simply inadequate. Nevertheless, this office, among others, views its responsibility as being to the claimant first, and, if possible, we try to win the case at the reconsideration level if the claimant comes in at that point.

The proposed Bill contemplates closing the record after reconsideration, but allowing the Administrative Law Judge to remand the case to the State Agency if there is additional medical evidence.

The end result of this is that conscientious Administrative Law Judges will be continually remanding cases to the State Agency, and the work will become clogged at that level and will approach crises proportions. It should be realized that some of the backlog with the Administrative Law Judges, if there is any significant backlog, is not the fault of the Administrative Law Judges, but rather can be laid to the GSA. We, in this office, appear before Administrative Law Judges located in White Plains, Bronx, Manhattan, Brooklyn, Jamaica, and Hempstead, Long Island. Each of these offices is in my view severally understaffed with support personnel and attorney assistance. Each of these offices has insufficient typing equipment, typing staff, and not one of them has word processing equipment. Most of these offices, despite having upwards of nine or ten Administrative Law Judges, have only one, two, or three hearing rooms. It is impossible to expect the Administrative Law Judges to do their job if they are not given adequate facilities to do it. Clearly, in my view, the Administrative Law Judges do not have adequate facilities to hold hearings. Most of the Administrative Law Judges hold hearings in their offices. Perhaps this Committee has never been at a hearing in an Administrative Law Judge's office with a Government Medical Advisor, a Vocational Expert, a Spanish Interpreter, a claimant, a claimant's doctor, the claimant's attorney, the Judge's hearing assistant, and the Judge. It is indeed an experience which we go through continually. Recently, one Judge in New York was backlogged over six months on his decisions which had been hand written because a typist was in an accident, and the Judge was unable to obtain another typist to do his work. The Administration has attempted to reconfigure office staff to some degree to alleviate this problem, however, it is not sufficient when a Judge in Hempstead advises me that some of his work is three months behind because of the lack of a typist.

Further, the assumption is made that a good deal of development is being done at the Administrative Law Judge level. This is not the case. Here in Region No. 2, we have what is called the *Martinez* decision, which requires that the Administrative Law Judge hold the hearing within ninety (90) days of the claimant's request for hearing, and issue a decision within one hundred and twenty (120) days. This effectively eliminates the Administrative Law Judge's staff from doing any development. Most of the time when we come into a case, these cases are at the hearing level, and the files are very thin. They lack the necessary hospital records, clinic records, and doctors reports. The claimants without counsel have a great difficulty in developing available medical evidence. Your Bill proposes to lay more of this responsibility at the State Agency level.

In numerous cases, I have requested State Agency personnel to hold a file pending my receipt of medical evidence. My office is one block away from the State Agency and we routinely send a messenger to the agency almost on a daily basis with what ever medical we have received on various cases. Invariably, when the file reaches the hearing level, we see that the evidence which we submitted is not in the possession of the Social Security Administration and was never considered by the State Agency. Apparently, the State Agency, under the present system, is in such a rush to be rid of the files that very little cooperation is given to the claimants or their attorneys submissions.

I agree with so much of the Bill that indicates pressure should be taken off the Administrative Law Judges process by reducing their responsibilities for cases which should have been fully developed at the State Agency level. However, as stated before, closing the record at the Administrative Law Judges level, will only result in a backlog of cases to the State Agency. Indeed, if the Administrative Law Judge process is to be smooth, perhaps the Administrative Law Judges should be able to obtain consultative examinations without going through the State Agency.

As a practitioner, I do agree that the reconsideration process should be extended to six (6) months. Also, the appeal time after the initial decision should be lengthened in order to effectuate more development, and dampen the knee-jerk tendency to file for reconsideration to meet the sixty (60) day deadline.

On the issue of own motion review, I can only state that an Administrative Law Judge has an opportunity to examine the credibility and demeanor of the witnesses which would not be afforded the Appeals Council. I do not object to own motion review, but I do believe that where an Administrative Law Judge has made a credibility finding, his decision should not be disturbed if favorable to the claimant. I do object to the fact that the Appeals council is not instituting own motion review of Administrative Law Judges denials except in extreme rare circumstances. Clearly, own motion review should work both ways and whether own motion reviews result in the benefit or detriment to the claimant whose case is being reviewed, should be immaterial.

With respect to the adjudicative guidelines being available at all levels, may I state that these guidelines are presently available at all levels, but the State Agency simply ignores them. The Social Security Administration recently enacted what is called a "grid", otherwise officially known as the Medical Vocational Guidelines. The State Agency Examiners either repeatedly ignore the "grid", or misuse it. Furthermore, in hundreds of cases that I have handled, State Agency Physicians have determined that a claimant does not meet the "Listings of Impairments" where clearly the evidence demonstrates that the claimant does meet the Listings. Finally, State Agency Reviewers will deny a case if the claimant has not been disabled the full twelve months. The Act specifies that a claimant must have been disabled for twelve months or have a condition which is expected to last for twelve months. Very rarely have I seen a State Agency determine that the condition is expected to last twelve months.

The proposed amendment on pain substantially restates the law as has been articulated on numerous occasions by the Social Security Administration in its regulations. In fact, prior to a revision in regulations in 1980, the regulation almost word for word stated what the proposed amendment provides. Such an amendment will not provide for any substantial change in adjudication.

Insofar as medical school courses and continuing education in disability are provided, as a practitioner in this area, I would certainly have no objection. Too many doctors are unfamiliar with the details required in assessing disability, and I am always quite disappointed to review medical reports which contain insufficient information and are phrased in a purely conclusory fashion.

On the other hand, I am also equally disappointed where a doctor has submitted a detailed report setting forth the findings leading up to a conclusion, only to have the report rejected by the Administration on the basis that the doctor has made a conclusion which he should have not made.

As to the issue of volume providers, all I can state is that some of them do a good job, and some do a poor job. What disturbs me most about the reports submitted by volume providers, is in the area of cardiological evaluations. Most of the volume providers who do cardiological evaluations in my area, do substandard examinations, and improperly interpret medical data, such as stress tests. In fact, the stress tests interpretations done by the volume providers are a strong bone of contention. Many of these doctors are unfamiliar with the requirements of the Listings, and do not know a positive stress test when they see one. Nevertheless, the idea of a volume provider of medical examinations should not be discounted. Usually when the claimant is referred to a Board Certified Specialist, a much more detailed comprehensive and favorable report as a result of a more comprehensive examination is provided. Too many of my clients have complained about orthopedic examinations, and I have heard time and time again, "the doctor did not even look at me". "The doctor did not undress me". "I was in there for two minutes", and other comments. A good orthopedic evaluation takes at least one-half hour of physical examination. As a result, we often find discrepencies between reports we may obtain from a Board Certified Physician who really examines the claimant and the volume provider. The most glaring discrepancy and the biggest problem in Social Security cases from an orthopedic standpoint is called "residual functional capacity check list" that doctors complete and attach to their reports. Since disability determination is by and large left more on the residual functional capacity check list than the doctor's actual findings, and many of these doctors place little thought into completing their residual functional capacity check list, claimants benefits are often times denied based thereon.

We have been subpoening these doctors for cross examination at hearings, and invariably they cannot support the opinions expressed on the check list.

With respect to judicial review, one of the reasons why the Courts are being clogged, is that Administrative Law Judges are deciding cases on incomplete records. Moreover, under the pressures from the Social Security Administration, and some Court decisions, Administrative Law Judges are reluctant to give an attorney time to develop a case, and often refuse to grant adjournments even for good cause. The Appeals Council has improved its review process, but, by and large will affirm the Administrative Law Judge if it believes there is substantial evidence to support its decision.

The Bill proposes a Social Security Court. This writer would not be adverse to a Social Security Court provided that the Judges receive life-time appointments and not limited appointments where the Judges would lose their sense of independence. In other words, if a Judge on a Social Security Court was perceived as being too liberal, pressure might be brought to bear that he would not be reappointed.

However, review of the Bill, up to this point, would appear to indicate that what is proposed in having the hearing level being accomplished at the second level of judication, and having the Administrative Law Judges sit basically as an Appeals Council. The present Appeals Council apparently would review the Administrative Law Judge favorable decisions only and then the case would go to the super Administrative Law Judge or the Social Security Court. While I have misgivings about a Social Security Court, I must admit that many of my cases are pending in Federal Courts for entirely too long. and if such a system could speed adjudication, then I would be in favor of it. However, I only would be in favor of such a decision if the Judges would receive life-time appointments. Otherwise, the system is subject to political pressures.

Finally, the Bill proposes to eliminate the Social Security attorney fee provisions. It opines that these provisions are paternalistic and interfere with the attorney-client relationship.

I must tell you that should these provisions be eliminated, you will effectively eliminate attorney representation except for those individuals who are very wealthy.

In this office, the average case requires twenty to thirty hours of work to prepare and present to the Court. The average client who comes in to our office has been out of work for some time and has no money to pay an attorney.

Accordingly, we work on a contingency basis which provides that we will receive a fee if we are successful. In most cases, the claimant will be required to shoulder expenses for medical examinations or evidence that may be required, but other than these expenses, the claimant has no liability regarding payment of attorney fees in advance. There are cases, such as termination cases, short period cases, or cases that the Administration inadvertently fails to withhold money from past due benefits to apply towards the attorneys fees. In our experience, we have rarely, if ever recovered sums over and above the withheld withholding approved by the Social Security Administration.

Bear in mind that attorneys do not like to accept cases where they must chase clients for fees. By the time a Social Security claimant gets his money, he is usually so backlogged in bills that the last person he will think about paying, is his attorney. In fact, many social security claimants who are being terminated cannot obtain counsel. We accept a good number of these cases, but we are one office and can only handle so much volume. Many cases are turned away despite the fact that they have merit. We can only handle so much. SSI cases are simply not accepted by our office. Recently, with the SSI offset provision on concurrent cases, we had to stop accepting concurrent, SSI, Title II cases, because the offset provision left insufficient funds for attorneys fees. In fact, we figure that we lost about twenty to thirty thousand dollars for cases we handled last Spring which were finally adjudicated subsequent to the disability offset amendments. We simply cannot get paid on those cases despite extensive services rendered to claimants.

Accordingly, some analysis of the attorney fee provisions is in order. It is recognized by the subcommittee that the purpose of the attorney fee provision in the Social Security Act was, originally to encourage and ensure adequate claimant representation. Notwithstanding this provision, Federal Courts and many Social Security Administrative Law Judges have expressed dissatisfaction with the fact that still not enough claimants are represented.

In a Title II case, the statute essentially provides for a contingent fee. A contingent fee is meaningless absent a fund from which the contingent fee can be paid. A contingency fee is subject to approval by the Administrative Agency, is probably the most perfect method of reaching the objective sought in the Social Security Act.

An examination of what Social Security litigation involves and of the other areas to which it is analogous are important.

Once again, we must base this analysis on the assumption that nobody likes to work free. The members of this Congressional Subcommittee, its staff, its counsel are all paid for their services and time. The Administrative Law Judges and Social Security personnel are paid for their time. Attorneys do not like to work for free either, but perhaps, attorneys more than another profession or trade give more of their time and effort "for free". Attorneys have overhead, rent, electricity, telephone, copy machines, professional library fees, secretaries' salaries, insurance, etc. and the like. Despite being a professional, an attorney must run a business. Traditionally, many social security claimants and many SSI claimants were represented by legal services. In recent years, the budget for legal services has been severely cut back, and these offices are closing their doors to representation of Social Security claimants. Some of them are trying to refer claimants to private counsel for representation. Inasmuch as there are no attorney fee provisions under the SSI Program, private counsel must turn away SSI Claims.

It should be recognized that Social Security is to some extent a hybrid. Social Security is somewhat like a personal injury litigation. It deals with medical issues and requires some degree of facility with medical terminology. The claimant has either been injured or become disabled by disease. He or she is unable to work (or claims to be) cannot pay the bills, his or her house is being foreclosed, or the rent is unpaid, the doctor has not been paid, and even worse, the claimant now is in need of an attorney, because the Social Security twice denied him benefits, and he must appear at a hearing before an Administrative Law Judge. In a personal injury case, the facts are similiar except the claimant has not heard from any insurance company and has not the foggiest idea how to proceed obtaining recompense for his injury. In any event, the claimant now comes to an attorney and knows too well that he cannot afford him. Fortunately, in both instances, the lawyer will take the case on a contingency basis. In most states, personal injury actions are handled on a one-third contingency or sliding scale fee fixed by the Court and reviewed by the Courts. In Social Security cases, there is a twenty-five (25) percent withholding from retroactive benefits which is held as a lien for any approved attorneys fees, which could either equal the twenty-five (25) percent, exceed the twenty-five (25) percent, or be less than twenty-five (25) percent.

In both instances, the attorney had an absolute lien once he entered the case and the action resulted in an award to the claimant. If there was no award to the claimant, there was no fee. In both instances, a neutral, impartial adjudicatory body, i.e., either the Court which had jurisdiction over the personal injury action, or the Social Security Administration, or Federal Court which had jurisdiction over the Social Security claim, also had jurisdiction over the fee. Thus, in numerous cases, the Social Security Administration would approve less than twenty-five (25) percent of the fee after evaluating the attorneys services. In many personal injury actions, Courts will aid a settlement, compelling a personal injury attorney to "eat" part of his fee. Social Security Law Judges are not required to approve twenty-five (25) percent fees. In fact, their jurisdiction is presently limited to fees in the amount of three thousand dollars maximum. Social Security personnel are required to fix fees considered reasonable under the criteria set forth by the appropriate regulations which generally are consistent with traditional criteria for approval of attorney's fees. Where an attorney's fee exceeds the sum of three thousand dollars, it must be approved either by the Appeals Council, or by the Regional Chief Administrative Law Judge.

Parenthetically, for an example of how people are deprived of attorney representation, one should take a look at the New York State No-Fault Law. This law effectively eliminated the majority of actions for personal injuries and imposed stringent restrictions upon attorneys fees. Claimants suddenly found themselves unable to obtain counsel especially in those actions which resulted in claims for medical treatment alone. The attorneys simply could not obtain payment. Thousands of individuals who have had no significant basic economic loss of permanent injuries are being denied necessary medical treatment by the insurance carriers who are fully aware that claimants can no longer obtain counsel to assist them with these actions.

It should also be recognized that Social Security is insurance. In any type of insurance claim, (once an attorney enters the picture, all payments are made out in two-party checks), the carriers recognize the attorney lien and realize that it would be bad faith to interfere with an attorney-client relationship. An attorney is aware that he has a lien which is secure because the carrier will deal with him as a duly appointed representative of his client. Like any other insurance program, the Social Security Act recognizes the need for some sort of lien to protect the claimant's right to obtain counsel, and to protect counsel's right to obtain a fee.

It should also be recognized that Social Security is compensation. When disability benefits were conceived implicit was a notion that people became disabled by diseases, off-the-job injury, as well as on-the-job injury. Since most states had enacted disability benefits laws which provided a short period of state-planned benefits, a waiting period was built into the Social Security Act to avoid double payment of state and federal benefits. Because Social Security is also compensation, a workers compensation offset was provided so as to prevent duplicative payments which might interfere with an individuals motivation to return to work because of receipt of excessive benefits. For those not disabled by Workers' Compensation injuries, there was no offset because presumably, there were no other benefits available to these unfortunate individuals.

Finally, looking to the Compensation Acts, it was recognized that counsel fees for representatives had to be secured and, moreover, subject to Social Security review and approval on the grounds that Social Security was in fact, "Compensation" and traditionally, all Compensation Acts regulate attorneys fees on the grounds that the Acts themselves are for the benefit of claimants, and claimants should be entitled to due process and the right to counsel, but these Acts also recognize that administrative efficiency built into the Acts necessitated less procedural legal work and that the level of complexity and services would vary from case to case. In other words, a flat contingency arrangement was purely inapproprate. Therefore, the statute provides for the Secretary to fix a reasonable attorneys fee. The ability to fix these fees was vested at each administrative level with a central office in Baltimore, Maryland, handling fees at the initial and reconsideration levels. The Administrative Law Judges handling fees at the Administrative Law Judge level, and the Appeals Council handling fees at that level. The Courts also had jurisdication over fees for matters before the Court.

It is noteworthy that there is one Compensation Act which requires attorneys to "chase their fees", and this is found in the Federal Employees' Workers Compensation Act. This writer who has spent five years in the practice of Social Security and Workers Compensation knows of only one attorney in the entire City of New York who takes these cases (Government Employees' Compensation cases, and then only once in a while. In contrast, there are many attorneys who practice before the New York State Board under a Compensation Act, which gives the Administrative Law Judge full power and authority to fix and approve a fee, and likewise many attorneys practice under the Federal Longshore Compensation Act, which also gives the claims examiners and the Administrative Law Judges the authority to fix fees.

Under the present system, Title II, Disability claimants who wish to obtain counsel, usually can do so without much trouble. Those claimants with SSI Claims and concurrent Title II, SSI Claims simply cannot obtain attorney representation.

Under the present economic climate, these individuals cannot obtain legal services or legal aid either. What is even more shocking in the proposed Bill, is the fact that not only does the Legislation seek to eliminate the attorneys fee provisions which have encouraged and nurtured a claimant's bar, but also wishes to exempt Social Security from the Equal Access to Justice Act.

Some of the termination cases that I am seeing could arguably be presented as administrative abuses against citizens. I speak specifically of several cases where mental patients have actually been confined to hospitals and yet have had benefits terminated. Rest assured, however, that if the attorney fee provisions are eliminated, you will eliminate claimant representation. Any claimant who walks into an attorney's office will be required to put up a substantial amount of money in escrow. In addition, you may also effectively eliminate the contingency aspect of such representation in that attorneys will want to be paid whether or not they win or lose a case.

Finally, the notion that the fee fixing authority given to the Social Security Administration is "paternalistic" is far fetched. Most judicial actions require some degree of approval of attorneys fees. As I indicated prior, personal injury actions in New York State and most other states are guided by either a contingency or sliding scale arrangement which was fixed by the Courts. Under the Federal Tort Claims Act, the Courts have jurisdiction over the fee and an attorney is limited to twenty-five (25) percent of the recovery. In matrimonial actions, an attorney must apply to the Court for fixing of a fee. In Civil Rights actions and various other types of actions in Public Interest cases, and Class Actions, Federal Courts require a detailed fee petition (just like the Social Security Administration), and review these stringently to arrive at reasonable attorneys fees.

As a taxpayer, I feel I am paying for this service. I do not feel that the fee approval authority vested in the Administration is so unduly burdensome that it must be done away with. The Administration has a responsibility to the taxpayers, to the claimants, and to the attorneys who practice before it. Moreover, I would suggest that if the fees awarded at the reconsideration level were more reflective of the services performed by the attorneys, the reconsideration process would be beefed-up of its own accord.

Recency of work requirements: Criticism has been made that the present twenty-forty quarters requirement does not give reasonable assurance that the loss of earnings generally is related to the disabling event. On the other hand, the disability requirements are generally so strict that if an individual is to be found disabled, such disability will be on medical and other grounds, and I would think that there is a presumption that if an individual is found disabled that the loss of earnings must be related to the disabling event.

Your Bill indicates several problems especially that of where an individual has gaps in the work record because of degenerative disease or remitting or exacerbating disease. It is this writer's opinion that the present quarters of coverage system should not be disturbed.

Substantial gainful activity and trial work: I agree that the SGA Level should be raised to the sum of $340.00. However, I believe that sum of $75 earnings for a trial work period should also be raised to approximately the sum of $340.00. I believe that it is a disincentive to a person to try to work if he earns the sum of $75.00 in one month and uses a month of trial work. At the present wate rates a person can earn $75.00 in two days, and then not be able to work again. Why should a claimant risk losing his benefits for the amount of $75.00? A trial work period should more accurately reflect the reality of trial work.

With respect to the Workers' Compensation offset, it is noted that some workers elect reduced retirement benefits to avoid the offset, and then elect disability benefits just before the age of 65 years in order to obtain the maximum benefit. I do not understand why this is under attack. A person's disability benefits are an ancillary benefit. The retirement benefit has been paid for.

With reference to the material regarding payment for consultative medical examinations, as I have stated prior in this letter, I believe many of these examinations are substandard because the doctors are simply not properly paid. A doctor is only receiving the sum of $50.00 for an examination. He must perform many more examinations to meet his basic expenses than if he were in private practice and receiving private rate fees. This goes without saying, and I believe the Committee recognizes this problem.

With reference to the interim benefits being enforced by the Courts: As an attorney, I have been against this development. It has caused the Administrative Law Judges to rush cases to hearing stage which are not ready and not prepared. This has caused a great deal of pressure in the Office of Hearings and Appeals. I believe these Court decisions should be legislatively overturned. In our office, we routinely have the claimant execute a waiver of these provisions in order that the Administrative Law Judge and the Administration is not unduly pressured into making an incorrect disability decision.

It makes little sense to pay a claimant interim benefits and then find him not disabled, and explain that he must pay the payments back. The likelihood of the recovery of such benefits is virtually nil, and the Administrative Law Judge and the Administration is being penalized for trying to develop a claimant's case.

As an attorney, I strongly support vocational rehabilitation for disability beneficiaries. I strongly support a revitalization of the program especially insofar as the proposal includes cases that have been terminated for medical recovery attributable to vocational rehabilitation services.

I would respectfully suggest that when a person enters vocational rehabilitation, benefits should be continued through the vocational rehabilitation process with the understanding that there be some limitation as to how long benefits will be paid.

Having worked with Vocational Counsellors and seeing the results of vocational rehabilitation, I believe this program more than any other will take individuals off the disability rolls. However, you cannot expect people to attend vocational rehabilitation if they cannot support themselves while doing so.

As a member of the Bar, I interview hundreds of clients seeking Social Security Disability Benefits. In a large majority of those cases, we screen out many applicants and refer them to Vocational Rehabilitation. I think this underscores the role attorneys play in the Social Security system. We do not take cases without merit. We screen out many cases which simply do not belong. I think the committee must strongly evaluate the role attorneys play in the Social Security system.

I also believe that if you legislate attorneys out of the Social Security system at the Administrative level, you will create an even greater back log in the Courts, whether the Court be a Social Security Court or the present Federal Court system.

I would respectfully request that you bring these comments to the attention of those serving on the subcommittee and publish this in the Congressional Record.

Respectfully submitted,

VICTOR FUSCO, Esq.,
President, New York Social Security Bar Association.

LAW OFFICES OF GARY F. GLENN,
New York, N.Y., March 22, 1982.

NEW YORK SOCIAL SECURITY BAR ASSOCIATION,
(Attention: Victor Fusco, President).

DEAR MR. FUSCO: I am writing you in order to voice my disbelief of the possibility of having the social security law changed through the elimination of the 25 percent withholding amount for attorneys. I believe that this would result in attorneys finding themselves unpaid for their services in many instances and may thereby reduce the quality of representation afforded to future applicants. The recipients of these benefits are usually in an extremely poor financial condition and if a check goes directly to these individuals then it would be unlikely that there would be anything left for the attorney. Another problem may develop in that attorneys may begin to refuse to represent people that could not afford to put a certain sum into escrow. Thus, these people would be unable to have representation should the proposed change take place. Thank you.

Cordially yours,

GARY F. GLENN, Esq.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., March 16, 1982.

Hon. J. J. PICKLE,
Chairman, Subcommittee on Social Security,
Washington, D.C.

DEAR MR. CHAIRMAN: I have enclosed a package of information provided to me by Mrs. Marjorie Ondo of Fenton, Michigan, concerning the Social Security Disability program and the ongoing review of eligibility. Mrs. Ondo has requested that I forward it to you for inclusion in the record of your hearing on this matter.

Sincerely,

DALE E. KILDEE,
Member of Congress.

Enclosure.

FENTON, MICH., *March 12, 1982.*

In want to have my case entered into the records of the Disability Hearing next Tues. & Wed.—under Rep. Pickle—H.R. 5700.

The government determined that I was disabled, in concurrence with my medical records and testimony of myself and my husband. Now, even though my condition has not improved, and my Dr. at the University of Michigan Hosp. states in his letter "Due to these limitations, I feel that Mrs. Ondo continues to be disabled and have recommended that she not pursue full-time employment," I am now being told I regained the ability for substantial gainful work; and I am no longer eligible for disability benefits.

This is a cruel and vicious attack on the credibility of myself, my family, my Dr., and the judge that awarded me my benefits. My benefits are to be stopped without "due process of law" and with total disregard to my Dr.'s professional opinion. I was told by the Lansing office that I should have never received benefits under the quote guidelines of "I do not have a missing limb, I don't shake from palsy all the time, and I am not dying." I can button buttons, zip zippers, and pick up small objects, therefore I am able to work. This reasoning is insane and Mr. Reagan's promise that the truly needy on SS would not be bothered was a lie.

MARJORIE ONDO.

MEMORANDUM
State of Michigan

DISABILITY DETERMINATION SERVICE

For
SOCIAL SECURITY CLAIMS
P.O. Box 30011, Lansing, MI 48909

NOTICE OF PENDING CESSATION FORM

Marjorie L. Ondo
12214 Overlook Drive
Fenton, MI 48430

Date: March 8, 1982
A/N: 372-38-3558
District: C-SB:rjl

Dear Ms. Ondo:

Our Agency has been gathering medical reports to help the Social Security Administration determine if you are still eligible to receive disability benefits. To be eligible for benefits, you must be unable to do any substantial gainful work because of your impairment.

We have obtained current reports about your impairment from Dr. Wooliscroft and University of Michigan.

These reports show you have trouble with double vision when you are tired or read and have some pain and numbness, but, you are able to see satisfactorily and you are able to button buttons, zip zippers, and pick up small objects. You have no ulceration or amputation of your fingers due to your Raynaud's. Therefore, you are ahble to work and you are not eligible for disability benefits as of March, 1982.

Based on this information, it appears you regained the ability for substantial gainful work in March, 1982, and your benefits will have to be stopped.

If you believe you are still disabled, you have the right to submit any additional evidence you wish to be considered. If we do not hear from you within 10 days, we will send your claim to the Social Security Administration who will make the formal decision. Therefore, if you wish to submit more evidence it is important that you contact us within 10 days from receipt of this notice, even though you may need more time to submit the evidence.

This is not a formal decision on your claim. Social Security will notify you when the formal decision has been made. If they determine you are no longer disabled, you will still receive benefits for the month in which your disability ended and for each of the two months after that month. Accordingly, the last benefit check to which you would be entitled is for the month of May, 1982.

Sincerely,

SBraker
S. Braker
Disability Examiner

TOLL FREE NUMBER: 1-800-292-2710
SASE
DDS-160 a32

Form Approved
OMB No. 072-R0529

WORK ACTIVITY REPORT—EMPLOYEE

Name of disabled person Marjorie Ondo	☐ Blind ☒ Not Blind	Social Security Number 372-38-3358

Name and Social Security Number of wage earner (if other than disabled person)

PRIVACY ACT NOTICE

The information requested on this form is authorized by Title 20 CFR 404.1523 and Title 20 CFR 410.923. The information provided will be used to further document your claim. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange of information between Social Security and another agency.

Please use this form to describe your work activity since (Date disability began or, if later, date of prior investigation) →	Date

ANSWER EACH QUESTION AS FULLY AS POSSIBLE

1. Employer Identification (Show last employer first)

A	1. Employer's name F.H.L. Listing Exchange	2. Employer's address P.O. Box 81 Fenton, Mi., 48430	3. Employer's telephone No. None	
	4. Title or name of your job Self-Employment Clerical work	5. Rate of pay (Show if per hour, day, month or year) Beginning $3. per listing 1. per sold Ending Currently $40. per wk.	6. Days worked per week 2	7. No. of hours worked per day 2
	8. Work began (Mo., day, year) 2/7/79	9. Work ended (Mo., day, year)	10. If ended give reason	
B	1. Employer's name	2. Employer's address	3. Employer's telephone No.	
	4. Title or name of your job	5. Rate of pay (Show if per hour, day, month or year) Beginning Ending	6. Days worked per week	7. No. of hours worked per day
	8. Work began (Mo., day, year)	9. Work ended (Mo., day, year)	10. If ended give reason	
C	1. Employer's name	2. Employer's address	3. Employer's telephone No.	
	4. Title or name of your job	5. Rate of pay (Show if per hour, day, month or year) Beginning Ending	6. Days worked per week	7. No. of hours worked per day
	8. Work began (Mo., day, year)	9. Work ended (Mo., day, year)	10. If ended give reason	

2. List any months in which you earned more than $75.00 after the date you filed your claim.

In each of these months the gross income was more than $75.00, however, after paying my clerical help and my office overhead (phone, utilities, office supplies, ins., etc.) and car expense there was no month I made over $75.00. My net profit in 1979 was $1,122. In 1980 I had a net loss of $173.

Do (did) your earnings include any other payment such as tips, bonus, child care, sick or vacation pay, free meals, room or transportation? ☐ Yes ☒ No

If yes, identify the employer(s) and what you were given and estimate the dollar value and how frequently received.

4. If either statement below applies to all jobs shown in item 1, please check.

a. I worked 3 months or less and stopped because of my injury or illness. ☐

b. I continued or returned to work for the same amount or more money and my duties and my work hours are the same as before my injury or illness. ☐

If you checked either of the blocks in item 4, skip to item 10 on page 3, then sign and date this form at the bottom of page 3. If neither block was checked, answer all following questions.

5. Special employment situation

Are or were you employed by a friend or relative or through a special training or rehabilitation program? ☐ Yes ☒ No

If yes, please explain how and why you were hired.

6. Job requirements Self-employment-clerical work with the help of my daughter & husband. There is no job title. I know of no one else that does the same type work.

Are (were) your job duties different from those of other workers with the same job title?

a. Shorter hours ☐ Yes ☐ No
b. Different pay scale ☐ Yes ☐ No
c. Fewer or easier duties ☐ Yes ☐ No
d. Extra help given ☐ Yes ☐ No
e. Lower production ☐ Yes ☐ No
f. Lower quality ☐ Yes ☐ No
g. Other differences (e.g., frequent absences) ☐ Yes ☐ No

7. Explanations of job requirements

Describe all yes answers in item 6. Identify the employer(s) for each yes answer (1A,B, and/or C).

I work 1½-2 hrs. two days per week. I talk on the telephone, write and do some typing and filing. I do this work at my own pace and with assistance from my family.

8. Special expenses

Describe any impairment related expenses that you paid which are necessary for you to work (for example, attendant care, medical devices, equipment, prostheses, or similar items or services).

section for additional space to answer any previous questions and to give any additional information you think will pful. Please refer to the previous questions by number, such as 3 (other earnings), 6 (job requirements).

#6
I would be unable to handle this part time employment without the help of my daughter and husband. My daughter does clerical work for me and has done so since I started my self-employment in 2/79. My husband also helps with the clerical work and runs errands. By working at home I am able to work for about ½ hour and then rest for 10 or 15 minutes. I maintain a restrictive schedule as instructed by my Dr. at the University of Michigan Hospital. (See attached letter from my Dr.)

If more space is needed, use an extra sheet.

10. Check the appropriate block below:

I am not receiving disability benefits. ☐

I am receiving disability benefits, and I understand that the information provided above may result in my benefits being stopped. I have been given the opportunity to submit any evidence I wanted and to make any statements concerning my claim. ☒

Read the following statement Sign and date, provide address and telephone number.

Knowing that anyone who makes a false statement or misrepresentation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, I certify that the answers to questions on this form are true.

A. Signature of claimant/beneficiary or representative	B. Date 2/10/82	C. Telephone no. & area code 313-629-2082

D. Mailing address (Number and street, apt. no., p.o. box, or rural route)
12214 Overlook Dr.,

E. City and state Fenton, Mi.,	F. Zip code 48430	G. County Livingston

THE UNIVERSITY OF MICHIGAN

UNIVERSITY HEALTH PLAN
S. AMBULATORY CARE BLDG
5TH LEVEL
ANN ARBOR, MICHIGAN 48109
(313) 763-2001

January 26, 1982

Re.: Ondo, Marge
Reg. No.: 1 531 626 3

Marge Ondo
12214 Overlook Dr.
Fenton, Michigan 48430

To Whom It May Concern:

Mrs. Ondo has been under my care at the University Health Plan for the past approximately 1 1/2 years. Prior to that she was under the care of Doctor F. Fitzgerald. She initially was seen in August 1978. At that time, symptoms included difficulty concentrating, dizziness, weakness, a clumsy feeling and emotional changes. Objective findings of nystagmus as well as a positive Romberg test and problems with coordination in the left hand were noted. During that admission in September 1978 the neurological dysfunction was confirmed by consultation with a neurologist. These problems had developed following exposure to formaldehyde in what has subsequently been recognized as a toxic reaction.

Since her initial evaluation, she has continued to have nystagmus as well as some problems with coordination of the left hand. In addition, she has developed Raynaud's phenomenon.

She finds that exertion as well as tiredness will exacerbate her symptomatology. She also notes that exposure to the cold weather will naturally precipitate her Raynaud's.

Due to these limitations, I feel that Mrs. Ondo continues to be disabled and have recommended that she not pursue full-time employment. Part-time employment as she is currently engaged in at home is reasonable.

If I can be of further assistance in clarifying Mrs. Ondo's condition, feel free to contact me.

Sincerely,
UNIVERSITY HEALTH PLAN
J.O. Woolliscroft MD
James O. Woolliscroft, M.D.
Team III

HP
D: 1/26/82
R: 1/28/82
T: 1/28/82
cc: Marge Ondo
12214 Overlook Dr.

[illegible]
P.O. [illegible]
Lansing, [illegible]

Refer to
Social Security Number
372-38-3358

Date January 6, 1982

C-RWJ:skc

Marjorie L. Ondo
12214 Overlook Drive
Fenton, MI 48430

The Social Security Administration has requested us to develop current evidence as to whether your condition still prevents you from working.

If at any time medical evidence shows that you are no longer disabled (or blind), you will still receive benefits for a 3-month period of adjustment. This period includes the month in which your condition is no longer disabling and 2 additional months. Benefits will then be stopped.

Pursuant to the Privacy Act of 1974, you are advised that 42 U.S.C. 421(a) authorizes the Social Security Administration to collect the personal information requested on this form to decide if you are still disabled. Your response is optional. However, if you do not provide the required information, a decision based on the evidence in your file can result in a determination that continuing eligibility for payments may cease.

The information you furnish on this form may be disclosed by SSA to another person or to another government agency for the following purposes:

1) to assist SSA in establishing your right to social security or black lung benefits and/or the amount thereof;
2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the programs administered by SSA; and
3) to comply with Federal laws requiring the exchange of information between SSA and another agency (such as the General Accounting Office).

To help us determine whether you are still entitled to disability (or blindness) benefits, please answer the questions on the next three pages. Sign your name at the bottom of the last page. In order to prevent possible overpayments of benefits to you return the form promptly. Use the postage-free preaddressed envelope enclosed. If you are unable to complete the form promptly let us know.

If you have any questions, or need help in filling out the form, please telephone or visit any social security office. The people there will be happy to help you. You can find the telephone number and address in the telephone directory listed under "Social Security Administration," or you can ask at your local post office. If you visit the social security office, please bring this letter with you.

R. W. Juttonen
Disability Examiner

Enclosure:
Pre-Addressed Envelope

Form SSA-454a F4 (9-80)
Destroy Prior Editions

AND HUMAN SERVICES
INISTRATION
TY OPERATIONS

Form Approved
OMB No. 72-R0910

SOCIAL SECURITY DISABLED PERSON REPORT

er monies or other benefits may be paid out under this program unless this report is completed and filed as required xisting public law 89-97

I understand that this report will be used to determine whether to continue or to stop my disability cash benefits. I also understand that if I am receiving social security disability benefits and supplemental security income payments, this questionnaire is applicable to both claims.

INSTRUCTIONS FOR COMPLETING THE FORM

Answer each question as fully as possible.

If any question does not apply to you, write "none" in the space provided,

If you need more space to answer a question, use the back of this form or a separate sheet of paper, If you use a separate sheet of paper, please be sure to put your social security claim number on it.

Answer all parts of the following questions:

1. (a) Do you feel that you are able to return to work?

☐ Yes ☒ No If "No," explain below.

(b) Has your doctor told you that you are able to return to work?

☐ Yes If the answer is "Yes," when?____________________ *(give date)*

☒ No ☐ Did not say

(c) Has the doctor placed any signficant restrictions on the kind of work you may do or how many hours a day you may work?

☐ No ☒ Yes If "Yes," explain below.

Describe below in your own words your present condition. Be sure to list what you are unable to do in terms of standing, walking, bending, or any other activity that interferes with your working.

I have a demyelinating disease. It is not recuperative.
My condition remains the same as stated in letter dated 2/5/80 from Faith Fitzgerald, M.D., The University of Michigan Medical School, Dept. of Internal Med.

I continue to become easily fatigued (being able to work at something for about 30 minutes and then having to rest for 10-15 min.). I still have vision problems (double vision and trouble focusing on items), and nystagmus with accompaning dizziness and nausea. I also continue to suffer episodic forgetfulness and headaches.
I am under instructions from my doctor to not become overtired, which means working and resting as indicated above. If I become fatigued my symptoms as indicated above become worse and my co-ordination and balance are more noticeably affected, and I require bed rest. Fatigue also brings on a burning pain in my hands and feet.

I also continue to have the symptoms of Raynaud's phenomena, consisting of a circulation problem in my hands and feet with resulting numbness and inability to use my hands during the attacks.

Considering all of these restrictions, it would be impossible and futile for me to try to return to work.

ddress, and telephone number of your physician(s) and of the hospital or clinic where you have received for the condition since you became entitled to benefits.

ME OF PHYSICIAN, HOSPITAL, OR CLINIC James Woolliscroft, M.D., University of Michigan, Univ. Health Plan, Internal Medicine Associates, Ann Arbor, Mi., 48109	DATE LAST TREATED 11/17/81
ADDRESS D5206 South Ambulatory Care Bldg. University Hospital, Ann Arbor, Mi., 48109	TELEPHONE NUMBER 763-2001
(b) NAME OF PHYSICIAN, HOSPITAL, OR CLINIC Faith Fitzgerald, M.D., Dept. of Internal Medicine, Univ. of Mich. Medical School, Ann Arbor, Mi., 48109	DATE LAST TREATED 7/21/80
ADDRESS (Dr. Fitzgerald left Univ. of Mich. and she referred me to Dr. Woolliscroft)	TELEPHONE NUMBER
(c) NAME OF PHYSICIAN, HOSPITAL, OR CLINIC	DATE LAST TREATED
ADDRESS	TELEPHONE NUMBER

3. If you have worked in the past 12 months, complete all of the following items:

(a) NAME, ADDRESS, AND TELEPHONE NUMBER OF EMPLOYER Self-employed at home with help of my daughter and husband.	(b) KIND OF WORK DONE Talking on phone, some typing.

(c) WHEN STARTED *(Date)*	(d) AVERAGE HOURS WORKED		(e) AVG. GROSS EARNINGS *(Before payroll deduct.)*	
	PER DAY	PER WEEK	PER DAY	PER WEEK
2/79		3-4		$40. (out of which I pay my daughter)

(f) ARE YOU STILL WORKING?

☒ Yes ☐ No *If "No," explain below why and give date you stopped working.*

etermined that you are not disabled, you may be eligible for continued payments if you are in an
ilitation program.

eiving help, such as services, training or counseling from the State vocational rehabilitation agency?
omplete the following: YES ☐ NO ☒

hat kind of help have you received, or do you expect to receive, and when?

(c) What is the name and address of your VR counselor?

5. Remarks:
Enter here any additional information that you believe is important and will assist in the review of your continuing entitlement to social security disability benefits. *(If you need more space, use a separate sheet of paper. Also, if you wish, you may attach any evidence that shows your current condition.)*

I do not feel it would be fair to an employer or myself to try to return to work knowing the restrictions on my activity. I would not be able to perform a job at the pace I have to maintain in order to avoid becoming fatigued. I know that if I try to push myself I end up having to spend time in bed, and as indicated the only treatment is what the Dr. calls "self-management"; that is a schedule to avoid fatigue, and the resulting consequences.

The Raynaud's phenomena is also of a disabling nature.

My family can testify to the statements contained herein and to the fact that I would very much like to return to work, but that my condition does not permit me to do so. They have seen me "overdo" my activities and end up in bed. My husband can verify that it is tiring for me just to make the trip to Ann Arbor to the Dr., as he is the one that takes me. They have also seen my attacks of Raynaud's and how it affects the use of my hands.

My husband and daughter can also verify that they assist me with my self-employment at home and with household chores.

I certify that the above statements are true, correct, and complete to the best of my knowledge. I know that anyone who fraudulently conceals or fails to report a disqualifying event or who makes a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act could be subject to a fine, imprisonment, or both.

SIGN YOUR NAME AS YOU USUALLY WRITE IT: ▶ x Marjorie L. Ondo
DATE: x 1-12-82
PHONE NUMBER: 313-629-2082

If the address shown on page one of this form is incorrect or incomplete please enter your present address below.

NUMBER AND STREET, APARTMENT NO., P.O. BOX, OR RURAL ROUTE

CITY
STATE
ZIP CODE

1/12/82

State of Michigan
Department of Education
Bureau of Rehabilitation
Disability Determination Service
P.O. Box 30011
Lansing, Mi., 48909

Gentlemen:

My wife's diagnosis of a demyelinating disease, most compatible with a toxic neuropathy remains the same as it was at the hearing before the Adminstrative Law Judge. Her present physician, Dr. Wooliscroft, has instructed her to maintain a daily schedule that is not tiring for her. If she attempts to continue her activity beyond the point that she starts to feel tired then she becomes so exhausted she requires bed rest. She becomes tired just making the trip to Ann Arbor to the Dr. She is also limited by her vision problems and is unable to read for any length of time. She becomes dizzy and nauseated due to the nystagmus and has trouble focusing. I have also witnessed her attacks of Raymaud's. Her hands become milk white and numb and she is unable to hold on to anything. This happens about 2 or 3 times per week.

My daughter and I help my wife around the house. I also do the cooking. I further help my wife with the clerical work she does at home. I run errands, pick up and make photocopies, do some filing and sorting. Her self-employment at home is more therapeutic then profitable. She has always been a hard worker and feels better being able to still do some work, although it is minimal. When she was first admitted to the Univ. of Michigan Hosp. she was totally exhausted and had tried to keep going to her job when she was just not able to handle it. It was very hard for her to accept the fact that she is unable to do everything she could before she became sick. She is now maintaining a restrictive schedule as ordered by her Dr. and would be unable to handle returning to work.

Very truly yours,

John Ondo

Re: Marjorie L. Ondo
12214 Overlook Dr.
Fenton, Mi., 48430
SS #372-38-3358

1/12/82

State of Michigan
Department of Education
Bureau of Rehabilitation
Disability Determination Service
P.O. Box 30011
Lansing, Mi., 48909

Gentlemen:

I agree with all of the statements made in regard to my mother's condition as contained in my father's letter of this same date. I help my mother with household chores and also assist her with her part-time employment. I have helped her with the clerical work since she started working at home in 2/79. She is not able to do all of the work herself and I assist with typing, filing, and other functions related to the work.

She is restricted in her activities as indicated in my father's letter, and I have also witnessed her attacks of Raynaud's and this happens as indicated in my father's letter.

Considering the impairments my mother suffers and the restrictions on her activity as witnessed by my father and I, my mother would not be able to return to work.

Very truly yours,

Sherri Ondo

Re: Marjorie L. Ondo
12214 Overlook Dr.
Fenton, Mi., 48430
SS #372-38-3358

MICH DEPT EDUCATION
PO BOX 30011
LANSING MI 48909

westernunion Mailgram

1-0068591i006002 01/06/82 ICS WA16614 LSGA
01934 MLTN VA 01/06/82

MARJORIE L ONDO
12214 OVERLOOK DR
FENTON MI 48430

PLEASE CALL ME IMMEDIATELY REGARDING YOUR CLAIM FOR SOCIAL SECURITY AND/OR SUPPLEMENTAL SECURITY INCOME BENEFITS. CALL TOLL FREE AT 1-800 292-2710 MONDAY THRU FRIDAY BETWEEN THE DAYTIME HOURS OF 8:00 & 12:00 OR 1:00 & 5:00.

R JUNTTONEN, DISABILITY EXAMINER
DISABILITY DETERMINATION SERVICE
LANSING, MI

1-517-373-7830
1-7-82

4734

12:46 EST

MGMCOMP

1-11-82

File shows formaldehyde poisoning, etc.

Dr. Fitzgerald's letter is in file

Final decision made by board that has Dr.'s on it.

There is an appeal process. 2 wks after papers rec'd. for Dr. records to be ck'd. at U of M

1-20-82

Everything rec'd o.K. per Mr. Junttonen & all papers are in order

1-25-82

Mr. Ludington - call SS office back in Flint

TO REPLY BY MAILGRAM, SEE REVERSE SIDE FOR WESTERN UNION'S TOLL - FREE PHONE NUMBERS

(over)

Social Security Award Certificate

230 522- [illegible]

Sue - Judge Stetter's Sec.

From: Department of Health, Education, and Welfare
Social Security Administration

Date 06/12/80

Marjorie L Ondo
12214 Overlook Dr
Fenton MI 48430

Claim Number: 372-38-3358 HA

Type of Benefit	Date of Entitlement	Monthly Benefit
DISABILITY	02/79	$482.60
	06/79	$530.40

Shortly after April 21, 1980 you will receive a payment for $4228.68 which represents all benefits due you through April 1980. Thereafter, a check for $530.40 will be sent to you each month.

You have stated that you have a workmen's compensation claim pending. You should notify any social security office when a decision is reached.

The change in benefit rates is due to the amendments to the Social Security Act.

You cannot receive monthly benefits based on another person's social security record when you are entitled to an equal or larger benefit based on your own record. Therefore, you will no longer receive the benefits previously paid to you as a parent. Your next payment will have been adjusted for the difference between benefits already paid and those now payable.

We are sending a copy of this notice to your attorney.

This action supersedes our previous determination and is in accordance with the decision of the Administrative Law Judge.

If you believe that this determination is not correct, you may request that your case be reexamined. If you want this reconsideration, you must request it not later than 60 days from the date you receive this notice. You may make any such request through any social security office. If additional evidence is available, you should submit it with your request.

cc: Grant Stetter
Administrative Law Judge
Social Security Administration
432 N Saginaw Rm 810
Flint MI 48502

cc: Paul Lazar
Attorney at Law
526 Mott Foundation Bldg
Flint MI 48502

This certifies that you (or the person(s) on whose behalf you applied), became entitled under the Social Security Act to the social security benefits shown.

Stanford G. Ross
Commissioner of Social Security

Important: See other side for additional information ▶

Form SSA-L30-C1(10-78)(Formerly SSA-30)

Additional Information About Your Claim

(Please disregard any unchecked items.)

☒ Section 206(a) of the Social Security Act requires an attorney to obtain authorization from the Social Security Administration before he or she may charge any fee for services. This section of the law also provides that up to 25 percent of a claimant's past-due benefits can be used toward the payment of such fees. When the amount of the fee is determined, it will be taken from the withheld funds and sent to your attorney; any remaining amount will be sent directly to you. If the authorized fee exceeds the amount withheld, payment of the balance of the fee is a matter to be settled between you and your attorney.

Since there was an attorney of record in this case and the amount of the fee has not yet been authorized, we are withholding $1392.24 . from

☐ your past-due benefits.

☒ the past-due benefits payable to you and your family.

If your attorney has not yet done so, he or she should immediately file a petition for approval of a fee or notify the Administration if no fee is to be charged.

☐ Since an attorney represented in the claim for benefits and the amount of the attorney's fee has not been determined, up to 25 percent of all past-due benefits must be withheld for use toward the payment of such fee. would not be entitled to benefits in this case unless had become entitled to benefits. Thus, the services of 's attorney assisted not only him or her but also . Therefore, we have withheld $ from the past-due benefits payable to you .

The Social Security Administration will authorize the fee the attorney may charge for services and will pay the authorized fee directly to the attorney from the withheld benefits. If the amount of the authorized fee is less than the total amount of withheld benefits, it will be paid proportionately from withheld benefits. Any of the withheld benefits not needed for payment of the authorized fee will be sent to you promptly.

SSA-960 (7-78) (Formerly Para No. 960)

Important: See other side for additional information ▶

Form SSA-L30-C1(10-78)(Formerly SSA-30)

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEARINGS AND APPEALS

DECISION

In the case of

Marjorie L. Ondo

(Claimant)

(Wage Earner)(Leave blank if same as above)

Claim for

Period of Disability and
Disability Insurance Benefits

372-38-3358

(Social Security Number)

This case is before the Administrative Law Judge upon a timely Request for Hearing filed by the claimant, who is dissatisfied with the prior determination disallowing an application for a period of disability under Section 216(i) [42 U.S.C. 416(i)] and for disability insurance benefits under Section 223 [42 U.S.C. 423] of the Social Security Act, as amended.

In view of the Administrative Law Judge's conclusion, which is wholly favorable to the claimant, full recitation of the evidence is unnecessary.

Review of the medical evidence reveals that Exhibits 16, 17, 19 and 27 were consequential in determining the claimant's impairments. Those records establish that the claimant suffers from: a form of demyelinating disease, which is most likely a neurological syndrome secondary to the toxic effects of formaldehyde exposure; depression and hypertension.

Mrs. Ondo appeared for a hearing in Flint, Michigan on February 25, 1980 accompanied by her husband and her attorney, Paul Lazar, Esq.

The testimony of the claimant and her demeanor, in the opinion of the undersigned, were significant and credible. She testified that she becomes fatigued after approximately 15 minutes' exertion and must sit or lie down for an equal period of time. She experiences problems with her hands and feet tingling and becoming numb, and at times cannot use her hands for periods varying from 15 minutes to three hours. She experiences these problems two or three times per week. Additionally, she has trouble with her eyes after looking at something up close, finding she cannot focus after periods varying from one-half hour to three hours of concentration. She has seen a psychiatrist for depression, but not for the past several months.

Also present and testifying was her husband who corroborated her testimony.

The testimony of Samuel Goldstein, a vocational expert whose qualifications are set forth in Exhibit 25, was pertinent and served to help substantiate the claimant's contentions. In his opinion, jobs do not exist in substantial numbers which claimant should be able to do because she loses the use of her hands frequently and she has difficulty concentrating and experiences periods of blurred vision.

Of particular importance were the reports of Mercywood Hospital in Ann Arbor, Erol Ucer, M.D., Faith Fitzgerald, M.D. and John D. Segall, M.D. of the University of Michigan Hospital. These reports clearly demonstrated the significant impairments suffered by the claimant.

After careful consideration of all the evidence of record, the Administrative Law Judge finds that the disability earnings requirements are met; and that beginning on August 17, 1978 (Exhibit 8), the claimant was under a "disability" as that term is defined in the Social Security Act, as amended, and that such disability has continued up to and through the date of this decision.

It is the decision of the Administrative Law Judge that the claimant, based on the application filed on May 4, 1979, is entitled to a period of disability commencing on August 17, 1978, and to disability insurance benefits under Sections 216(i) and 223, respectively, of the Social Security Act, as amended.

The undersigned finds that the claimant suffers from a severe impairment and is unable to engage in substantial gainful activity, even that of a sedentary nature.

The undersigned finds claimant would benefit by seeking psychological counseling, individual or group. If she fails to do this, benefits must be terminated.

Grant Stetter

Grant Stetter
Administrative Law Judge

Date: MAR 2 1 1980

Form HA-518-U9 (11-78)
(Formerly HA-518)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

OFFICE OF HEARINGS AND APPEALS
432 N. SAGINAW ST., RM. 810
FLINT, MICHIGAN 48502
PHONE 234-5621, ext. 331

REFER TO

BUREAU OF
HEARINGS AND APPEALS

A/N: 372-38-3358

March 21, 1980

Marjorie L. Ondo
12214 Overlook Dr.
Fenton, MI 48430

Dear Ms. Ondo:

I have completed my action on your case and have concluded that you are entitled to a period of disability commencing on August 17, 1978 and to disability insurance benefits. A copy of my decision has been sent to your representative, Paul Lazar, Esq.

Very truly yours,

Grant Stetter
Administrative Law Judge

cc: Paul Lazar, Esq.
526 Mott Foundation Bldg.
Flint, Michigan 48502

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEARINGS AND APPEALS

NOTICE OF HEARING

In case of

Marjorie L. Ondo
(Claimant Wage Earner)

372-38-3358
(Social Security Number)

Claim For
Period of Disability and
Disability Insurance Benefits

TO: Mrs. Marjorie L. Ondo
12214 Overlook Dr.
Fenton, MI 48430

Pursuant to your written request and provisions of section 205(b) of the Social Security Act, a hearing will be held by the undersigned, an administrative law judge of the Bureau of Hearings and Appeals, on Monday (Day of Week), February 25, 1980 (Full Date) at 11:00 o'clock in Room 810 of Metropolitan Building, 432 N. Saginaw St. (Number and Street) Flint (City), Michigan 48502 (State)

The general issues to be determined are whether you are entitled to a period of disability under section 216 (i) and to disability insurance benefits under section 223(a).

The specific issues to be decided are: (1) Whether you have the required insured status under the law; and if so, as of what date(s); (2) The nature and extent of your impairments; (3) Whether your impairment has lasted or can be expected to last for a continuous period of at least 12 months, or can be expected to result in death; (4) Your ability to engage in substantial gainful activity since your impairment began; (5) When your disability, if any, began.

This hearing involves your application(s) filed on 5/4/79 (Date)

You should be prepared to prove that you were under a disability on or before date of the hearing (Date).

It may be to your interest to have your physicians appear at the hearing to testify on your behalf. Be prepared to furnish: your entire work history, including names of employers, dates of employment and a description of duties performed; schools and training; names of physicians who have examined or treated you; and periods of hospitalization with names of hospitals.

REMARKS: Please read all attachments.

IMPORTANT – Please sign and return at once the enclosed postal card notifying me whether you will be present at the above time and place. No postage is required on this card.

Administrative Law Judge Grant Stetter Grant Stetter/J. F.		Mail Address Office of Hearings & Appeals 432 N. Saginaw St., Rm. 810 Flint, MI 48502
Date Jan. 30, 1980	Telephone Number 234-5621, ext. 331	

cc: Representative (Name and Address)
Paul Lazar, Esq., 526 Mott Bldg., Flint, MI 48502

Social Security Office (Address)
929 Stevens St., Flint, MI 48502

Enclosure

READ THE OTHER SIDE OF THIS NOTICE FOR FURTHER INFORMATION REGARDING YOUR HEARING

FORM HA-507.1
(4/75)

CLAIMANT

(Over)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BUREAU OF HEARINGS AND APPEALS

1-14-80 Mrs. Honser – Judge Stetter (Mar. or Apr.) hearing

REQUEST FOR HEARING

– 2-25-80 - 11 AM

Take or Mail original and all copies to your local Social Security Office.

CLAIMANT
Marjorie L. Ondo

WAGE EARNER (Leave blank if same as above)

SOCIAL SECURITY NUMBER
372-38-3358

SPOUSE'S NAME AND SOCIAL SECURITY NUMBER
(Complete ONLY in Supplemental Security Income Case)

(Check One)
Initial Entitlement ☐
Termination or other Post-Entitlement Action ☐

432 N. Sag., Rm. 810 Metro Bldg.
Flint 48502
(send add. med. to him)

Type Claim (Check ONE)
Retirement or Survivors — Only ☐ (RSI)
Disability, Worker or Child — Only ☒ (DIWC)
Disability, Widow or Widower — Only ☐ (DIWW)
SSI, Aged — Only ☐ (SSIA) With Title II Claim ☐ (SSAC)
SSI, Blind — Only ☐ (SSIB) With Title II Claim ☐ (SSBC)
SSI, Disability — Only ☐ (SSID) With Title II Claim ☐ (SSDC)
Other (Specify)

I disagree with the determination made on the above claim and request a hearing. My reasons for disagreement are:

Fatigue upon physical exertion, limitation of movement due to nausea & dizziness.

I do not seem to be getting my point across on these written forms.

Check one of the following:
☐ I have additional evidence to submit (Attach such evidence to this form or forward to the Social Security Office within 10 days.)
☒ I have no additional evidence to submit.

Check ONLY ONE of the statements below:
☒ I wish to appear in person.
☐ I do not wish to appear at a hearing. I request that a decision be made on the basis of the evidence in my case.

Signed by: (Either the claimant or representative should sign. Enter addresses for both. If claimant's representative is not an attorney, complete Form SSA-1696.)

SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE **Paul Lazar** ☒ ATTORNEY ☐ NON ATTORNEY	CLAIMANT'S SIGNATURE
ADDRESS **526 Mott Foundation Bldg.**	ADDRESS **12214 Overlook Dr.**
CITY, STATE, AND ZIP CODE **Flint, Mi., 48502**	CITY, STATE, AND ZIP CODE **Fenton, Mi., 48430**
TELEPHONE NUMBER **767-8800**	TELEPHONE NUMBER **629-2082**

DATE: **12/14/79**
(Claimant should not fill in below this line)

TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION

Is this request timely filed? ☒ YES ☐ NO
If "No" is checked: (1) Attach claimant's explanation for delay. (2) Attach any pertinent letter, material, or information in the Social Security Office.

Interpreter Needed ____ (Language)

ACKNOWLEDGMENT OF REQUEST FOR HEARING

This request for hearing was filed on ____ at ____
The Administrative Law Judge will notify you of the time and place of the hearing at least 10 days in advance of the hearing.

[redacted]

For the Social Security Administration:
By: ____ (Signature)
(Title)
(Street Address)
(City, State, and Zip Code)
Servicing Social Security Office Code 3647

Form HA-501 US (6-78)

CLAIMANT

48430

Social Security Notice

From: Department of Health, Education, and Welfare
Social Security Administration

Date: OCT. 16, 1979

Claim Number: 372-38-3358 HA

MARJORIE L ONDO
12214 OVERLOOK DR
FENTON MI 48430

UPON RECEIPT OF YOUR REQUEST FOR RECONSIDERATION WE HAD YOUR CLAIM FOR DISABILITY INSURANCE BENEFITS INDEPENDENTLY REVIEWED BY A PHYSICIAN AND DISABILITY EXAMINER IN THE STATE AGENCY WHICH WORKS WITH US IN MAKING DISABILITY DETERMINATIONS. THE EVIDENCE IN YOUR CASE HAS BEEN THOROUGHLY EVALUATED; THIS INCLUDES THE MEDICAL EVIDENCE AND THE ADDITIONAL INFORMATION RECEIVED SINCE THE ORIGINAL DECISION. WE FIND THAT THE PREVIOUS DETERMINATION DENYING YOUR CLAIM WAS PROPER UNDER THE LAW.

TO BE CONSIDERED DISABLED, A PERSON MUST BE UNABLE TO PERFORM ANY SUBSTANTIAL GAINFUL WORK DUE TO A MEDICAL CONDITION WHICH HAS LASTED OR CAN BE EXPECTED TO LAST FOR A CONTINUOUS PERIOD OF AT LEAST 12 MONTHS. THE IMPAIRMENT MUST BE SO SEVERE AS TO PREVENT THE PERSON FROM WORKING NOT ONLY IN THE PERSON'S USUAL OCCUPATION BUT IN ANY OTHER SUBSTANTIAL GAINFUL WORK CONSIDERING AGE, EDUCATION, TRAINING, AND WORK EXPERIENCE. THIS CONDITION MUST BE DISABLING AT A TIME WHEN THE PERSON MEETS THE EARNINGS REQUIREMENT OF THE LAW.

THIS NOTICE CONCERNS ONLY YOUR SOCIAL SECURITY DISABILITY APPLICATION. IT IS NOT A DECISION AS TO WHETHER RETIREMENT, SURVIVORS, HOSPITAL AND MEDICAL INSURANCE, OR SUPPLEMENTAL SECURITY INCOME BENEFITS ARE PAYABLE.

IF YOU BELIEVE THAT THE RECONSIDERATION DETERMINATION IS NOT CORRECT, YOU MAY REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE OF THE BUREAU OF HEARINGS AND APPEALS. IF YOU WANT A HEARING, YOU MUST REQUEST IT NOT LATER THAN 60 DAYS FROM THE DATE YOU RECEIVE THIS NOTICE. READ THE ENCLOSED LEAFLET BHA-1 FOR A FULL EXPLANATION OF YOUR RIGHT TO APPEAL.

IF YOU DO NOT REQUEST A HEARING OF YOUR CASE WITHIN THE PRESCRIBED TIME PERIOD, YOU STILL HAVE THE RIGHT TO FILE ANOTHER APPLICATION AT ANY TIME.

IF YOU HAVE QUESTIONS ABOUT YOUR CLAIM, YOU SHOULD GET IN TOUCH WITH ANY SOCIAL SECURITY OFFICE. MOST QUESTIONS CAN BE HANDLED BY TELEPHONE OR MAIL. IF YOU VISIT AN OFFICE, HOWEVER, PLEASE TAKE THIS LETTER WITH YOU.

IN ADDITION YOU ARE NOT ENTITLED TO ANY OTHER BENEFIT BASED ON THE APPLICATION YOU FILED.

ENCLOSURE HEW (SSA) 77-10282 BHA-1

Form SSA-L951-C1 (8-77)

C

C 79283

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
SOCIAL SECURITY ADMINISTRATION

TOE 710

Form Approved
OMB No. 72-R0552

REQUEST FOR RECONSIDERATION

(Do not write in this space)

NAME OF CLAIMANT
Marjorie L. Ondo

NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (If different from claimant)

SOCIAL SECURITY CLAIM NUMBER
372-38-3358

SUPPLEMENTAL SECURITY INCOME CLAIM NUMBER

SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (Complete ONLY in Supplemental Security Income Case)

CLAIM FOR (Specify type, e.g., retirement, disability, hospital insurance, supplemental security income, etc.) disability

I do not agree with the determination made on the above claim and request reconsideration.

My reasons are: Even though I have 20/20 vision, I do have a focusing problem (blurred & double vision) after I use my eyes for close work for 3-4 hours. Further in connection with my eyes I have headaches & nystagmus with accompanying dizziness & nausea. I am dizzy & nauseated each day to varying degrees. I also tire very easily & find it necessary to lay down at times during the day because I just can't keep going any longer. I further am now experiencing pain in my feet, hands, & arms, which has been disabling some days.

NOTE: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice of the determination.

I am submitting the following additional evidence (If none, write "None.")

Letter dated 6/28/79 from Dr. Faith T. Fitzgerald at the U. of M. verifying the above statement.

Signature (First name, middle initial, last name) (Write in ink)
SIGN HERE ▶ Marjorie L. Ondo

Date (Month, day, year)
9/12/79

Telephone Number
629-2082

Mailing Address (Number and street, Apt. No., P.O. Box, or Rural Route)
12214 Overlook Dr., Fenton, Mi. 48430

City and State
Fenton, Mi.

ZIP Code
48430

Enter Name of County (if any) in which you now live
Livingston

Witnesses are required ONLY if this request has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. Signature of Witness

2. Signature of Witness

Address (Number and street, City, State, ZIP Code)

Address (Number and street, City, State, ZIP Code)

FOR SOCIAL SECURITY OFFICE USE ONLY

SOCIAL SECURITY OFFICE ADDRESS

ROUTING INSTRUCTIONS (Check one)

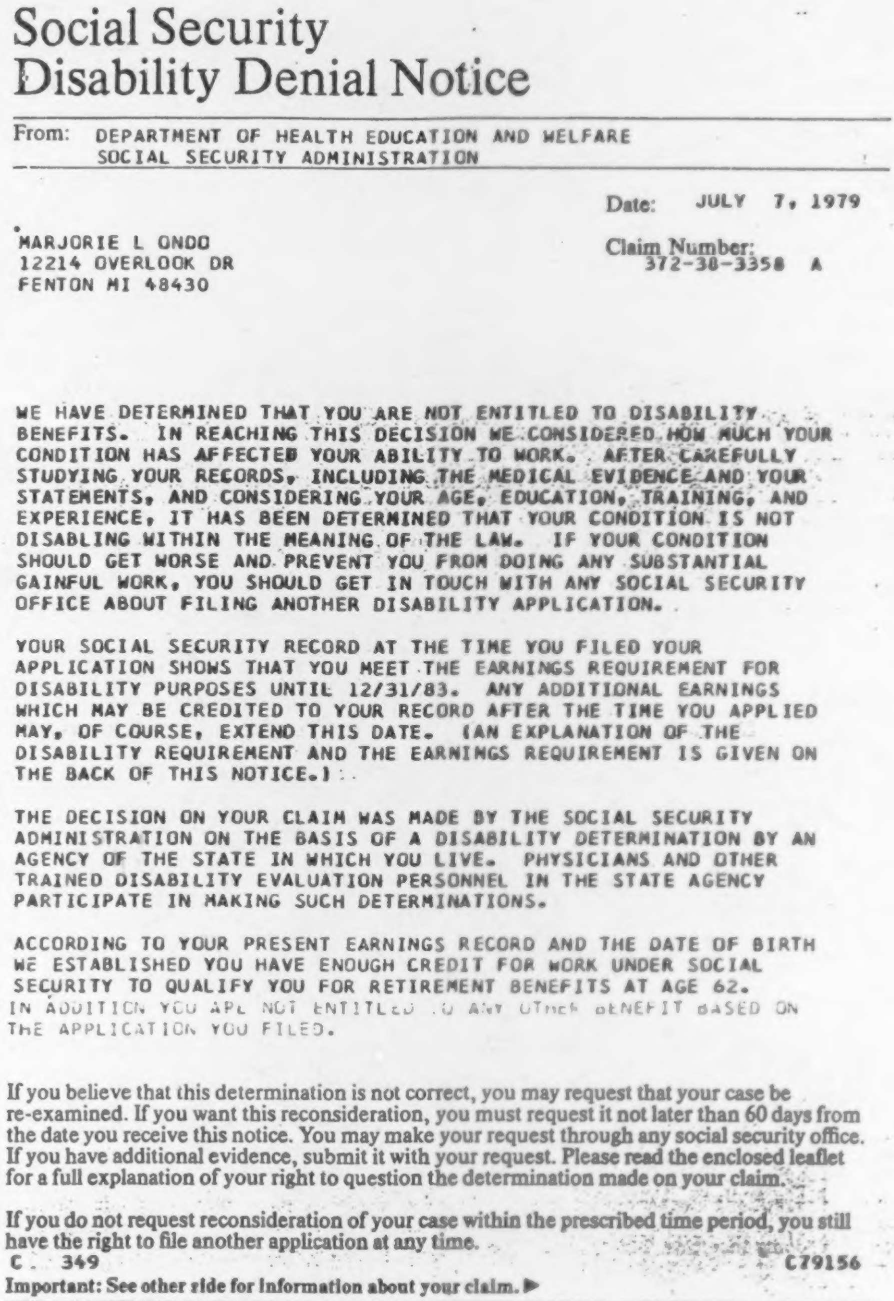
☐ State Agency (Route with disability folder)
☐ Program Service Center
☐ BDI, Balto.

District Office Reconsideration [illegible]

[illegible]

FORM SSA-561 (3-76)

NOTE: Take or mail completed copies to your Social Security Office.



Social Security Disability Denial Notice

From: DEPARTMENT OF HEALTH EDUCATION AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Date: JULY 7, 1979

MARJORIE L ONDO
12214 OVERLOOK DR
FENTON MI 48430

Claim Number:
372-38-3358 A

WE HAVE DETERMINED THAT YOU ARE NOT ENTITLED TO DISABILITY BENEFITS. IN REACHING THIS DECISION WE CONSIDERED HOW MUCH YOUR CONDITION HAS AFFECTED YOUR ABILITY TO WORK. AFTER CAREFULLY STUDYING YOUR RECORDS, INCLUDING THE MEDICAL EVIDENCE AND YOUR STATEMENTS, AND CONSIDERING YOUR AGE, EDUCATION, TRAINING, AND EXPERIENCE, IT HAS BEEN DETERMINED THAT YOUR CONDITION IS NOT DISABLING WITHIN THE MEANING OF THE LAW. IF YOUR CONDITION SHOULD GET WORSE AND PREVENT YOU FROM DOING ANY SUBSTANTIAL GAINFUL WORK, YOU SHOULD GET IN TOUCH WITH ANY SOCIAL SECURITY OFFICE ABOUT FILING ANOTHER DISABILITY APPLICATION.

YOUR SOCIAL SECURITY RECORD AT THE TIME YOU FILED YOUR APPLICATION SHOWS THAT YOU MEET THE EARNINGS REQUIREMENT FOR DISABILITY PURPOSES UNTIL 12/31/83. ANY ADDITIONAL EARNINGS WHICH MAY BE CREDITED TO YOUR RECORD AFTER THE TIME YOU APPLIED MAY, OF COURSE, EXTEND THIS DATE. (AN EXPLANATION OF THE DISABILITY REQUIREMENT AND THE EARNINGS REQUIREMENT IS GIVEN ON THE BACK OF THIS NOTICE.)

THE DECISION ON YOUR CLAIM WAS MADE BY THE SOCIAL SECURITY ADMINISTRATION ON THE BASIS OF A DISABILITY DETERMINATION BY AN AGENCY OF THE STATE IN WHICH YOU LIVE. PHYSICIANS AND OTHER TRAINED DISABILITY EVALUATION PERSONNEL IN THE STATE AGENCY PARTICIPATE IN MAKING SUCH DETERMINATIONS.

ACCORDING TO YOUR PRESENT EARNINGS RECORD AND THE DATE OF BIRTH WE ESTABLISHED YOU HAVE ENOUGH CREDIT FOR WORK UNDER SOCIAL SECURITY TO QUALIFY YOU FOR RETIREMENT BENEFITS AT AGE 62. IN ADDITION YOU ARE NOT ENTITLED TO ANY OTHER BENEFIT BASED ON THE APPLICATION YOU FILED.

If you believe that this determination is not correct, you may request that your case be re-examined. If you want this reconsideration, you must request it not later than 60 days from the date you receive this notice. You may make your request through any social security office. If you have additional evidence, submit it with your request. Please read the enclosed leaflet for a full explanation of your right to question the determination made on your claim.

If you do not request reconsideration of your case within the prescribed time period, you still have the right to file another application at any time.

C . 349 C79156

Important: See other side for information about your claim. ▶

Department of Health, Education, and Welfare
Social Security Administration

Form SSA-L793-C1 (10-77) (Formerly SSA-L793)
Prior editions may be used until supply is exhausted

DEPARTMENT OF HEALTH EDUCATION AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Mrs. Ulrich - 11-1-79

DISABILITY DETERMINATION AND TRANSMITTAL

06/27/79 tj

1 DESTINATION: DDS ☒ BDI ☐ CRS ☐ DIO ☐
2 DDS CODE: 230
3 FILING DATE: 05/04/79
4 SSN: 372-38-3358

5 NAME AND ADDRESS OF CLAIMANT:
Mrs Marjorie L Ondo
12214 Overlook Dt
Fenton Mi 48430
Genesee Co

6 WE'S NAME (If CDB or DWB Claim):

7 TYPE CLAIM (Title II): DIB ☒ FZ ☐ DWB ☐ CDB-R ☐ CDB-D ☐ RD-R ☐ RD-D ☐ RD ☐ P-R ☐ P-D ☐
8 TYPE CLAIM (Title XVI): DI ☐ DS ☐ DC ☐ BI ☐ BS ☐ BC ☐

9 DATE OF BIRTH: 07/21/37
10 PRIOR ACTION: ☐ PD ☐ PT
11 REMARKS: ph 313-629-2082
12 DISTRICT-BRANCH OFFICE ADDRESS: 929 Stevens St Flint MI 48502
DO-BO CODE: 349
13 DO-BO REPRESENTATIVE: J West DRTE
14 DATE: 5/07/79

DETERMINATION PURSUANT TO THE SOCIAL SECURITY ACT, AS AMENDED

15 CLAIMANT DISABLED: A ☐ DISABILITY BEGAN ____ B ☐ DISABILITY CEASED ____
16 DIAGNOSIS:
Hypertension
Depression
Possible formaldehyde poisoning
17 RE-EXAM: ☐ NONE ☐ ____ (Date)
18 CASE OF BLINDNESS AS DEFINED IN SEC. 1614(a)(2)/216(i): A ☐ NOT DISAB FOR CASH BENE PURP B ☐ DISAB FOR CASH BENE PURP BEG ____
19 CLAIMANT NOT DISABLED: A ☒ THROUGH DATE OF CURRENT DETERMINATION B ☐ THROUGH ____ C ☐ BEFORE AGE 22 (CDB Only)
20 VOCATIONAL BACKGROUND: Real Estate/secretary
OCC YRS: 14
ED YRS: 12
21 VR ACTION: SC IN A ☒ SC OUT B ☐ PREV REF C ☐
22 REG-BASIS CODE: F1-1502(a)
23 MED LIST NO:
24 MOB CODE: G
25 REVISED DET: ☐
26 LIST NO:

27 RATIONALE U of M 08/30/78-04/09/79; Mercywood Hospital 10/22/78-11/21/78; H. Golden, M.I Internist C/E 06/15/79. Medical evidence reveals essentially normal neurological examination. Hearing is adequate and vision is excellent. The W/E has a history of hypertension but there is no end organ damage. The W/E was hospitalized 5 weeks for depression and the W/E responded well to treatment. Currently mental status is unremarkable. From the evidence in file it appears the W/E's impairment is not severe.

☐ SEE ATTACHED SSA-834

28 A ☐ PERIOD OF DISABILITY B ☐ DISABILITY PERIOD C ☐ ESTAB BEG ____ AND D ☐ CONTINUES E ☐ TERM ____
29 LTR/PAR NO:
30 DISABILITY EXAMINER-DDS: E. Raven C-Eleanor Raven
31 DATE: 6/27/79
32 REVIEW PHYSICIAN-DDS: (MD)
33 DATE: 6/27/79
34 REMARKS:

35 BASIS CODE:
36 REV. DET. CODES:
37 SSA REPRESENTATIVE:
SECTION:
38 DATE:

FORM SSA-831 U5 (5-78) (FORMERLY SSA-831)
PRIOR EDITIONS MAY BE USED UNTIL SUPPLY IS EXHAUSTED

1 - FOLDER COPY

MEMORANDUM
State of Michigan
DISABILITY DETERMINATION SERVICE
FOR
SOCIAL SECURITY CLAIMS
P.O. Box 30011, Lansing, Michigan 48909

NOTICE OF DISABILITY EXAMINATION FORM

Concerning:

Marjorie Ondo
TO: 12214 Overlook Drive
Fenton, MI 48430

06/01/79 C-ER/ph
Appl. Ph.
629-2082
On Social Security Account
# 372-38-3358

The Social Security Administration has asked our agency to help determine if you are eligible for disability benefits. They will inform you when the final decision is made.

Our staff physicians feel a special examination is necessary. We will pay for the examination. The doctor's office will notify you of appointment details. (This is not an authorization for treatment.)

Your appointment is Friday, June 15, 1979 at 9:00 a.m. with H. Maxwell Golden, M.D. 218 E. Court St., Flint, MI 48503--phone 239-6441. Please telephone the doctor's office immediately confirming this appointment. No treatment will be given.

2 blks E. of Sq. - between Clifford + Harrison
(Court exit St. + turn left -)

If you are unwilling to have the examination or have a problem please contact us as soon as possible. You may call toll free 1-800-292-2710. If you do not have this examination, the decision will be based on the medical evidence now in the file and could result in denial or cessation of benefits for lack of proof of disability.

Please complete the enclosed "Applicant Reply" form, and return it to us immediately. **WE MUST RECEIVE YOUR ANSWER WITHIN 5 DAYS OF THE RECEIPT OF THIS LETTER.**

Sincerely,

Eleanor Raven
Eleanor Raven
Disability Examiner

If you cannot keep the appointment, call the doctor immediately. **Failure to call at least 24 hours in advance may be considered "lack of cooperation".**

DDS-2 L. (3/79)

42 APPLICANT COPY

Enc: SSA 79-10087

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No.72-R1047

For SSA Use Only - Do NOT Complete This Item.

Name of Wage Earner	Social Security Number
Name of Claimant	Social Security Number
Type of Claim:	

Title II — ☐ Freeze ☐ DIB ☐ DWB ☐ CDB Title XVI — ☐ Disability ☐ Blind ☐ Child

RECONSIDERATION DISABILITY REPORT

PLEASE PRINT, TYPE, OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, answer all questions. COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.

Privacy Act Notice: The information requested on this form is authorized by Title 20 CFR 404.1523 and Title 20 CFR 416.923. The information provided will be used to further document your claim. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to social security programs and to comply with Federal laws requiring the exchange of information between the Social Security Administration and another agency.

PART I — INFORMATION ABOUT YOUR CONDITION

1. Has there been any change (for better or worse) in your illness or injury since you filed your claim? ☒ Yes ☐ No
   If "Yes," describe any changes in your symptoms.

   I am now also experiencing pain in my feet & hands & pain in my arms.

2. Describe any physical or mental limitations you have as a result of your condition.

   Episodic forgetfullness.

   Unable to work at something for an extended length of time due to fatigue, headaches, nausea & dizziness. Also at times have disabling pain in feet, hands & arms. The only shopping I do is grocery shopping once a week because of nystagmus with accompaning nausea & dizziness which is accentuated by the looking around required when shopping.

3. Have any restrictions been placed on you by a physician? ☒ Yes ☐ No
   If "Yes," give name, address, and telephone number of the physician and show what kinds of restrictions have been imposed.

   Dr. Faith Fitzgerald, U. of M. Medical School, Ann Arbor, Mi. 764-5115.
   Not to overdue -to rest when I feel tired, & restrict "looking around" with eyes when nauseated & dizzy.

4. Do you have any additional illness or injury that isn't recorded in the file? ☐ Yes ☒ No
   If "Yes," describe the kind of illness or injury and the date that it occurred.

PART II — INFORMATION ABOUT YOUR MEDICAL RECORDS

5. Have you seen any physician since you filed your claim? ☒ Yes ☐ No
If "Yes," provide the following about the physician you last visited.

NAME
Dr. Faith T. Fitzgerald, M.D.

ADDRESS (Include ZIP Code)
The University of Michigan Medical School
Ann Arbor, Mi., 48109

AREA CODE AND TELEPHONE NUMBER
313-764-5115

HOW OFTEN DO YOU SEE THIS PHYSICIAN
Monthly

DATES YOU SAW THIS PHYSICIAN
5/23/79, 6/27/79, 7/25/79

REASONS FOR VISITS
Follow-up

TYPE OF TREATMENT RECEIVED (Include drugs, surgery, tests)
Checking of previously mentioned conditions.

6. Have you seen any other physician since you filed your claim? ☐ Yes ☒ No
If "Yes," show the following:

NAME

ADDRESS (Include ZIP Code)

AREA CODE AND TELEPHONE NUMBER

HOW OFTEN DO YOU SEE THIS PHYSICIAN?

DATES YOU SAW THIS PHYSICIAN

REASONS FOR VISITS

TYPE OF TREATMENT RECEIVED (Include drugs, surgery, tests)

If you have seen other physicians since you filed your claim, list their names, addresses, dates and reasons for visits in Part V.

7. Have you been hospitalized, or treated at a clinic or confined in a nursing home or extended care facility for your illness or injury since you filed your claim? ☐ Yes ☒ No
If "Yes," show the following:

NAME OF FACILITY

ADDRESS OF AGENCY (Include ZIP Code)

PATIENT OR CLINIC NUMBER

WERE YOU AN INPATIENT? (Stayed at least overnight)
☐ Yes ☐ No IF YES, SHOW →

DATES OF ADMISSIONS AND DISCHARGES

WERE YOU AN OUTPATIENT?
☐ Yes ☐ No IF YES, SHOW →

DATES OF VISITS

REASON FOR HOSPITALIZATION, CLINIC VISITS, OR CONFINEMENT

TYPE OF TREATMENT RECEIVED (Include drugs, surgery, tests)

If you have been in other hospitals, clinics, nursing homes, or extended care facilities for your illness or injury, list the names, addresses, patient or clinic numbers, dates and reasons for hospitalization, clinic visits, or confinement in Part V.

8. Have you been seen by other agencies for your injury or illness? ☐ Yes ☒ No
(VA, Workmen's Compensation, Vocational Rehabilitation, Welfare, Special Schools, Unions, etc.)
If "Yes," show the following:

NAME OF AGENCY

ADDRESS OF AGENCY (Including ZIP Code)

YOUR CLAIM NUMBER

DATES OF VISITS

NAME OF COUNSELOR, SOCIAL WORKER, ETC.

TYPE OF TREATMENT OR EXAMINATION RECEIVED (Include drugs, surgery, tests)

If more space is needed, list the other agencies, their addresses, your claim numbers, dates, and treatment received in Part V.

PART III — INFORMATION ABOUT WORK

9. Have you worked since you filed your claim? ☒ Yes ☐ No

A few hours weekly as indicated on previous application.

If "Yes," you will be asked to give details on a separate form.

PART IV — INFORMATION ABOUT YOUR ACTIVITIES

10. How does your illness or injury affect your ability to care for your personal needs?

I am working a few hours weekly out of my home, only with the help of my daughter & husband. I am unable to handle all of the household chores, as I was able to do in the past, again requiring the help of my husband & daughter for cooking, cleaning, etc. My family further assists by running errands (banking, going to post office, etc.) If I work a few hours in a day that is absolutely all I can handle without help. This is the first year I haven't gone shopping with my daughter for school clothes, simply because it makes me dizzy & nauseated to shop.

11. What changes have occurred in your daily activities since you filed your claim? (If none, show, "None")

Basically the same as when claim was filed, and as mentioned in #10.

PART V — REMARKS AND AUTHORIZATIONS

12.(a) READ CAREFULLY: I authorize the Social Security Administration to release information from my records, as necessary to process my claim, as follows:

Copies of my medical records may be furnished to a physician or a medical institution for background information if it is necessary for me to have a medical examination by that physician or medical institution. The results of any such examination may be given to my personal physician.

Information from my records may also be furnished, if necessary, to any company providing clerical and administrative services for the purposes of transcribing, typing, copying or otherwise clerically servicing such information. The State Vocational Rehabilitation Agency may also have access to information in my records to determine my eligibility for rehabilitative services.

I understand and concur with the statement and authorizations given above, except as follows (If there are no exceptions, write "None" in the space below. If you do not concur with any part of the above statement, state your objections clearly):

None

12. (b)	Telephone number where you can be reached: 629-2082	Best time to reach you: 9:00 - 3:00 P.M. daily

2(b) • Use this section to continue information required by prior sections. Identify the section for which the information is provided.
Note: This section may also be used for any special or additional information which you wish to be recorded

Letter from Dr. Faith T. Fitzgerald dated 6/28/79 is enclosed, in which she covers the problems of burning pain in feet & fingertips; double vision; episodic forgetfulness; & nausea associated with rapid eye movement (nystagmus). She mentions ~~discrete/~~ central nervous system signs. Also enclosed is another copy of letter dated 1/26/79 to which she refers & which was previously furnished.

I mentioned to the SS Dr. H. Maxwell Golden, M.D., the problems I was having with my eyes, even though when I take a test with the eye chart I have 20/20/ vision.

The Social Security determination made said I have excellent vision, with no mention of the blurring/double vision & nystagmus with accompaning nausea & dizziness. It also indicated no neurological problems (of which nystagmus is one), & this statement in the determination is not consistent with the medical information available at the U. of M. & as contained in the enclosed letters. Dr. John D. Segall, M.D., U.ofM. Dept. of Neurology mentions in his out-patient notes the vision problem I am having, the nystagmus, difficulty I was experiencing with left side coordination.

The SS determination further makes no mention of the fatigue that I continue to experience, which was also mentioned to Dr. Golden.

I would very much like to be able to work all day, come home & take care of my house, go on shopping trips, as I was able to do in the past & be free from the nausea, dizziness, headaches, pain & fatigue. Dr. Fitzgerald has indicated to me that she does not expect the condition to improve. At this time, I don't feel it would be fair to myself or an employer to try to work full time.

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal Law, I certify that the above statements are true.

NAME (SIGNATURE OF CLAIMANT OR PERSON FILING ON THE CLAIMANT'S BEHALF)
SIGN HERE Marjorie L. Ondo
DATE 9-12-79

Form SSA-3441 F6 (9-78)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 72-R1042

C-ER

VOCATIONAL REPORT

This report supplements the Disability Report (Form SSA-3368) by requesting additional information about your past work experience. PLEASE PRINT, TYPE, OR WRITE CLEARLY AND ANSWER ALL ITEMS TO THE BEST OF YOUR ABILITY. If you are filing on behalf of someone else, enter his or her name and social security number in the space provided and answer all questions. COMPLETE ANSWERS WILL AID IN PROCESSING THE CLAIM.

Privacy Act Notice: The information requested on this form is authorized by Title 20 CFR 404.1523 and Title 20 CFR 416.923. The information provided will be used to further document your claim. Information requested on this form is voluntary, but failure to provide all or any part of the requested information may affect the determination of your claim. Information you furnish on this form may be disclosed by the Social Security Administration to another person or governmental agency only with respect to social security programs and to comply with Federal laws requiring the exchange of information between Social Security and another agency.

A. Name of Claimant	B. Social Security Number	C. Telephone number where you can be reached:
Marjorie L. Ondo	372-38-3358	313-629-2082

PART I — INFORMATION ABOUT YOUR WORK HISTORY

1. List all jobs you have had in the last 15 years before you stopped working. (If you have a 6th grade education or less, AND performed only heavy unskilled labor for 35 years or more, list all of the jobs you have had *since you began to work. If you need more space, use Part III.)*

	JOB TITLE (Be sure to begin with your usual job)	TYPE OF BUSINESS	DATES WORKED (Month and Year)		DAYS PER WEEK	RATE OF PAY (Per hour, day, week, month or year)
			FROM	TO		
1	Real Estate Sec.	Real Estate	7/10/78	8/18/78	5	$275. a wk.
2	Secretary/Office Mgr./ Closing Officer	Real Estate	2/64	6/23/78	5	$242. a wk. plus %
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

PART II — INFORMATION ABOUT YOUR JOB DUTIES

e the following information (on pages 2-5) for each of the jobs listed in Part I starting with your usual job.

e (from Part I):

In your job did you:	• Use machines, tools, or equipment of any kind?	☒ Yes	☐ No
	• Use technical knowledge or skills?	☒ Yes	☐ No
	• Do any writing, complete reports, or perform similar duties?	☒ Yes	☐ No
	• Have supervisory responsibilities?	☒ Yes	☐ No

B. Describe your basic duties (explain what you did and how you did it) below. Also, explain all "Yes" answers by giving a FULL DESCRIPTION of: the types of machines, tools, or equipment you used and the exact operation you performed; the technical knowledge or skills involved; the type of writing you did, and the nature of any reports; and the number of people you supervised and the extent of your supervision:

Last job at Realty World Schaefer consisted of compiling of information for the closing of real estate deals, preparing the paperwork for same and processing the file after closing.
The job prior to that consistdd of the same work, plus I attended all closings as the closing officer. I also made deposits for the real estate Trust Acct. & handled the Trust Acct. ck. book (balancing the acct., etc.) I worked with the salespeople in co-ordinating closings & was available to advise them on deals. In the past, at the same job, I had also been office manager & handled collection of rental & land contract payments-maintaining the rental sheets & land contract payment sheets. I further paid all bills for the company and took care of all check books including the Trust Acct.
The above jobs required-

1. Typing
2. Filing
3. Telephoning & writing
4. Making bank deposits
5. Writing cks. & maintaining ck. book bal.
6. Using adding machine & calculator
7. Using copy machine
8. Maintaining rental ledger-sending late notices, call re: rental repairs.
9. Order title work & other nec. papers on closings.
10. Attend closings & process file.

C. Describe the kind and amount of physical activity this job involved during a typical day in terms of:

- **Walking** (circle the number of hours a day spent walking) — 0 [✓ 1] 2 3 4 5 6 7 8
- **Standing** (circle the number of hours a day spent standing) — 0 [✓ 1] 2 3 4 5 6 7 8
- **Sitting** (circle the number of hours a day spent sitting) — 0 1 2 3 4 5 [✓ 6] 7 8
- **Bending** (circle how often a day you had to bend) — Never [✓ - Occasionally] - Frequently - Constantly
- **Reaching** (circle how often a day you had to reach) — Never [✓ - Occasionally] - Frequently - Constantly
- **Lifting and Carrying**: Describe below what kind of objects or material was lifted, how much it weighed, how many times a day you lifted this material, and how far you carried it.

Papers & files & checkbook & dep. book were handled. Papers & files were worked with on desk & file cabinet was about 3 ft. from desk. File was taken to closing.

PART III — REMARKS

Section for any other information you may want to give about your work history, or to provide any other remarks
y want to make to support your disability claim:

(If you need more space, use separate sheets of paper.)

Knowing that anyone making a false statement or representation of a material fact for use in determining a right to payment under the Social Security Act commits a crime punishable under Federal law, I certify that the above statements are true.

NAME (SIGNATURE OF CLAIMANT OR PERSON FILING ON THE CLAIMANT'S BEHALF)

SIGN HERE ▶ X Marjorie L. [illegible] DATE 5-16-74

Do not write below this line

SSA-3369 TAKEN BY
☐ PERSONAL INTERVIEW
☐ TELEPHONE ☐ MAIL

FORM SUPPLEMENTED ☐ YES ☐ NO
If "Yes," by
☐ PERSONAL INTERVIEW ☐ TELEPHONE ☐ MAIL

SIGNATURE OF INTERVIEWER OR REVIEWER

TITLE *(also check office)*
☐ DDS ☐ DO ☐ BO

DATE

MEMORANDUM

State of Michigan
DISABILITY DETERMINATION SERVICE
FOR
SOCIAL SECURITY CLAIMS
P.O. Box 30011, Lansing, Michigan 48909

REQUEST FOR ASSISTANCE FORM

Ms. Marjorie L. Ondo
12214 Overlook Drive
Fenton, MI 48430

May 14, 1979
A/N: 372-38-3358
Unit: C-ER/sm

We have sent a letter to Dr. Trollman asking questions about the medical problems you listed in your application for Disability Benefits. Sometimes we do not receive a prompt reply to our request because the doctor is too busy to answer our letter right away or the letter gets misplaced.

Because we would like to make the earliest possible decision on your claim, we would like you to call your Doctor's office and ask:

1. If the doctor has our request and when the report will be sent.
2. If the doctor has the information we requested in the existing records. We are not authorizing your doctor to perform a disability examination at this time.
3. If the doctor is too busy, on vacation, or for some other reason will not be able to send in a report.

It is most important to your claim that you call your doctor five days after you receive this letter. This will allow time for your doctor to receive our request.

Please call us at the number listed below as soon as you have talked to your doctor to let us know what you found out. If you have any questions about this form or what to do, please call immediately. Our office is open from 8:00 a.m. to 5:00 p.m., Monday through Friday.

If there is any charge for this report, you are responsible for paying that fee.

Sincerely,

Eleanor Raven

Eleanor Raven sm
Disability Examiner
Phone: (517) 373-7830 ext. 358

DDS-66 (1/79)

APPLICATION FOR DISABILITY INSURANCE BENEFITS

A REMINDER TO ([illegible])
APPLICANTS FOR SOCIAL
SECURITY DISABILITY
BENEFITS

SSA OFFICE
929 Stevens
371 Flint, Mi
48502

DATE
5-4-79

234-5626 ext. 266

Mr Koutouzos 12:15-12:30—

Your application for social security disability benefits has been received. You will be notified by mail as soon as a decision is made on your claim. In the meantime, if you change your address, or if there is some other change that may affect your claim, you — or someone for you — should report the change. The changes to be reported are listed on the next page. Always give us your claim number when writing or telephoning about your claim. If you have any questions about your claim, we will be glad to help you.

CLAIMANT	SOCIAL SECURITY CLAIM NUMBER

Collection and Use of Information from Your Application — Privacy Act Notice

I. The Social Security Administration is authorized to collect the information on this form under sections 223(a) and 205(a) of the Social Security Act, as amended (42 U.S.C. 423(a) and 405(a)).

II. While it is not mandatory, except in the circumstances explained below, for you to furnish the information on this form to social security, no benefits may be paid unless an application has been received by a social security office. Your response is mandatory where the refusal to disclose certain information affecting your right to payment would reflect a fraudulent intent to secure benefits not authorized by the Social Security Act.

III. The information on this form is needed to enable social security to determine if you and your dependents are entitled to insurance coverage and/or monthly benefits.

IV. Failure to provide all or part of this information could prevent an accurate and timely decision on your claim or your dependent's claim, and could result in the loss of some benefits or insurance coverage.

V. Although the information you furnish on this form is almost never used for any other purpose than stated in Part III, above, there is a possibility that for the administration of the social security programs or for the administration of programs requiring coordination with the Social Security Administration, information may be disclosed to another person or to another governmental agency as follows:

1. To enable a third party or an agency to assist social security in establishing rights to social security benefits and/or coverage (e.g., private medical and vocational consultants for making medical examinations or vocational assessments).
2. To comply with Federal laws requiring the release of information from social security records (e.g., to the General Accounting Office and the Veterans Administration).
3. To facilitate statistical research and audit activities necessary to assure the integrity and improvement of the social security programs (e.g., to the Bureau of the Census and private concerns under contract to social security).

(Over)

CHANGES TO BE REPORTED — DISABILITY APPLICANTS

☑ You change your mailing address for checks or residence. *To avoid delay in receipt of checks you should ALSO file a regular change of address notice with your post office.*

☑ You go outside the U.S.A.

☑ Any beneficiary dies or becomes unable to handle benefits.

☑ Custody Change — Report if a person for whom you are filing or who is in your care dies, leaves your care or custody, or changes address.

☑ Change of Marital Status — Marriage, divorce, annulment of marriage.

☑ You return to work (as an employee or self-employed) regardless of amount of earnings.

☑ Your condition improves.

☑ *If under age 62,* you begin to receive workmen's compensation (including Black Lung benefits) or the amount of present workmen's compensation payment changes.

An agency in your State that works with us in administering the social security disability program is responsible for making the disability decision on your claim. In some cases, it is necessary for them to get additional information about your condition or to arrange for you to have a medical examination at Government expense.

HOW TO REPORT

You can make your reports by telephone, mail, or in person, whichever you prefer. It is usually easier to mail in a reporting form to your Social Security office at the address shown above.

THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL,
Ann Arbor, Mich., February 5, 1980.

To Whom it May Concern:

Mrs. Marjorie Ondo, a 42 year old married woman, has been my patient at the University of Michigan, Ann Arbor since August 30, 1978. When I first saw her in that year she described a significant exposure to formaldehyde followed by weight loss, loss of equilibrium and physical findings which consisted of nystagmus, clumsiness of the left hand and decreased vibratory sensation in the lower extremities. I admitted her to hospital for more extensive evaluation. She was found by Neurology to have a markedly positive Rhombert test, abnormal cerebellar function, decreased position sense in all four extremities and decreased vibratory sense in the lower extremities. Laboratory studies included normal skull x-rays, EEG, spinal tap, and electrostagmograph. None of these helped to delineate the diagnosis, amongst which possibilities multiple sclerosis, toxin, infections, and neoplasm were considered most likely. During this hospitalization Mrs. Ondo also had anisocoria which was transient and has not recurred. An electromyogram showed large motor unit action potentials and decreased recruitment patterns in the C8 through T1 muscles in the right hand. After extensive evaluation it was felt that Mrs. Ondo's most likely diagnosis was some form of demyelinating disease which Dr. Sid Gilman felt most compatible with a toxic neuropathy. Since that time she has continued to have her neurologic findings, including nystagmus. She has most recently developed a classical Raynaud's phenomena (as of her visit of January 30, 1980) and I am proceeding to evaluate her for the possibility of vascular disease.

Sincerely,

FAITH FITZGERALD, M.D.,
Director, Medical Student Teaching
Programs, Internal Medicine.

THE UNIVERSITY OF MICHIGAN MEDICAL SCHOOL,
Ann Arbor, Mich., June 28, 1979.

PAUL LAZAR,
Neal & Lengauer, Attorneys at Law,
Mott Foundation Building, Flint, Mich.

DEAR MR. LAZAR: I am delighted to respond to your inquiry on Mrs. Marjorie L. Ondo, your file number 5001-9. I saw Mrs. Ondo in the office yesterday where she continues to have neurologic symptoms consisting now of burning pains of her feet and fingertips, which may be characteristic of peripheral nerve damage. Though I could elicit no discrete signs of this on physical examination, the symptoms are certainly compatible with neuropathy. She has a heavy metal screen in the urine pending, since exposure to certain heavy metals (such as lead) can give this same sort of dysfunction. On her preceding visit on 5/23/79 she continued to have double vision, episodic forgetfulness, and nausea associated with rapid eye movement. All of these findings are consistent with those neurologic symptoms with which she presented, and the impression for which is probably best summarized in Dr. Sid Gilman's letter of 1/26/79: This is, that though she has discrete central nervous system signs suggestive of multiple sclerosis, there is no other evidence of that disease and an intoxication syndrome, such as could conceivably result from formaldehyde, is to my mind most likely.

I believe that you have her early hospital records, but am enclosing them, nonetheless, should you not have received them. Please let me know if I could be of any further help.

Sincerely,

FAITH T. FITZGERALD, M.D.,
Director, Inpatient Programs.

UNIVERSITY HOSPITAL,
Department of Internal Medicine.

Re Ondo, Marjorie.

J. L. TRALLMAN, D.O.,
Fenton, Mich.

DEAR DR. TRALLMAN: We recently had the pleasure of evaluating your patient, Mrs. Marjorie Ondo, on the General Medicine Service at the University of Michigan Medical Center. As you know, Mrs. Ondo is a forty year old woman who has complained of fatigue of several months duration. She has a past history of hypertension and of borderline diabetes which has been diet controlled. She began employment in a real estate office this spring and began to have rhinitis, increased eye irritation, diplopia, tinnitus, and a headache, and a diagnosis of formaldehyde poisoning was made. The office insulation was made of a formaldehyde-urea form of material and measured formaldehyde levels by the Federal Government were toxic. In June she quite her job but her symptoms have remained, especially an overwhelming sense of fatigue which bothers her the most. There are also been anorexia with a twenty pound weight loss since December. The patient has also been bothered by palpitations for several months. Her hair is dry, thinking is slow and difficult, and she has had early morning awakening. Recently her physician started Elavil and gave her an injection simultaneously but approximately two hours later the patient became dizzy and passed out, falling down her basement stairs. The patient was referred by a friend of hers to Doctor Faith Fitzgerald of this department, who arranged for Mrs. Ondo's admission for further evaluation.

On admission Mrs. Ondo's medications were Inderal 10 mg TID, Dyazide 1 BID, Minipress 1 BID in the recent past and Elavil and Sinequan recently. She is allergic to Penicillin and to IVP dye. Her hospitalizations in the past have been for a tonsillectomy as a child and for an appendectomy and ovarian cyst removal at age 20. The patient has been told she has no right kidney. She has a history of postpartum depression treated with electroconvulsive therapy sixteen years ago.

On physical examination Mrs. Ondo was a middle-aged woman with rather flat affect, in no distress. Her blood pressure was 136/90, her pulse was 108 and her respirations were 14 per minute. She weighed 115½ pounds. There is no evidence of eye trauma. Examination of the eyes showed that the pupils were equal, round and reactive to light and accommodation, on initial physical examination. However, there was persistent nystagmus on right and left lateral gaze of greater than ten beats. There was also some vertical nystagmus on upward gaze but none on downward gaze. Fundi were seen with good sharp discs and no evidence of glaucoma or vessel abnormalities. Examination of the ears, nose and throat was within normal limits. The breasts were without masses. Chest exam was clear. Cardiac exam revealed no murmurs or extra sounds or similar abnormalities. Abdominal exam was completely normal. Pelvic was also normal. The patient was menstruating at the time of the pelvic exam and a speculum examination was not done, but bimanual disclosed a normal cervix with a normal uterus. There were numerous bruises and contusions over the body, most notably on the right dorsal hand and on the right and left knees and anterior tibial surfaces. In addition each of the great toes appeared to be cyanotic. Mental status showed that the patient was oriented times three, did several sevens perfectly back to 44, could repeat seven digits forward and four backward, and knew the presidents back to Eisenhower. Cranial nerves II–XII were within normal limits. However, the Romberg was markedly positive.

Finger to nose showed dysmetria with past pointing. Hoffmann's were negative. Abdominal reflexes were present. There was decreased position sense in both lower and upper extremities and decreased vibratory sense in both lower extremities. Pinprick and pain sensation was intact. There was a negative Adson's maneuver for thoracic outlet syndrome.

The initial impression was first fatigue of unknown etiology and second neurological problem of unclear etiology. The neurological problem was manifested with objective findings of nystagmus, positive Romberg, dysmetria, decreased vibratory sense.

Shortly after admission Mrs. Ondo was seen by Doctor Faith Fitzgerald, the attending physician, who concurred with the House Staff's plans for diagnosis and treatment. Laboratory examinations obtained included a hemoglobin of 14.6, hematocrit 42%, white blood count of 8700. Her electrolytes were completely normal as was her BUN of 17, creatinine of .8 and glucose of 117. Calcium was 10.5. Liver function tests were within normal limits and the uric acid was 5.0. Other laboratory tests obtained including a Westergren sedimentation rate of 19, a negative rheumatoid factor, a T-4 of 6.6 and a T-3 resin of 104 which were normal thyroid function tests. Urine analysis was normal as was serum protein electrophoresis and quantitative immunoglobulins. A VDRL and FTA for syphilis were normal as were hepatitis B antigen and antibody tests. Because of the possibility of peripheral neurophaty B-12 and Folate levels were obtained which were normal. Urine porphyrins were also normal. A PPD skin test was placed which was negative while a candida skin test was placed which was positive, indicating that there was no active tuberculous infection.

Because of our inability to explain these findings, the patient was seen in consultation by Doctor Siegel of the Neurology Section. It was his impression that there was, indeed, evidence for neurological dysfunction in the posterior fossa manifested by nystagmus, gait disturbance and diplopia. Among the possible etiologies suggested by Doctor Siegel were demyelinating disorders such as multiple sclerosis, toxic causes and infections such as vestibulitis, and possibly even a neoplasm such as a cerebello-pontine angle tumor. At the suggestion of the Neurologists, skull x-rays with views of the internal auditory canals were obtained which were normal. An EEG was obtained which was normal. Spinal tap was performed which showed an opening pressure of 140 mm, a protein of 36, a glucose of 73 with a simultaneous serum glucose of 125, two red blood cells and one white blood cell which was mononuclear per cmm. These are normal results. A CSF IgG to albumin ratio is showed large motor unit, action potentials and decreased recruitment pattern in the C8–T1 innervated muscles in the right hand. This was felt to be a nonspecific finding but the possibility of a lesion in the C8–T1 root level or the medical cord or lower trunk could not be ruled out. Other studies obtained to rule out the possibility of a bizarre systemic disease causing Mrs. Ondo's symptomatology included an ultrasound of the pancreas as carcinoma of the pancreas can be associated with strange neurological symptoms. This ultrasound was negative. Films of the cervical spine were obtained which showed cervical ribs as well as a spina bifida occulta at the level of C5. Thoracic spine films showed hypoplastic twelfth ribs and minor changes consistent with degenerative joint disease. An ANA is pending.

On September 8th the patient was noted to be anisocoric for the first time. Her right eye had a pupil of approximately 5 mm diameter as the left eye's pupil was 3 mm in diameter. This finding was again brought to the attention of the Neurologists who were unable to explain it.

At this point the Neurology consultant felt that the next logical step to proceed with work-up was with electronystagmograph to further study the patient's objective nystagmus. However, this test could not be arranged for a period of at least two weeks' time. The patient was accordingly discharged both because this test could not be arranged and because we wished to follow Mrs. Ondo's clinical evolution. It was feared by the consultants that her course is definitely consistent with an organic central nervous system lesion, perhaps a demyelinating disease.

Accordingly, Mrs. Ondo was discharged on September 9, 1978. Her discharge medications are Inderal 10 mg TID and Diuril 1 tablet BID. She is to return to see Doctor Faith Fitzgerald in the Faculty Diagnostic Unit in two weeks' time. At that point, consideration will be given to arranging an ENG and to arranging Neurology follow-up, perhaps including a CT scan.

Thank you very much for permitting us to participate in the care of this most fascinating patient. If we can be of any further assistance in this case, please do not hesitate to contact the undersigned.

FAITH FITZGERALD, M.D.,
Attending Physician.
MARTIN BROWER, M.D.,
Resident Physician.

MRS. MARJORIE ONDO, HISTORY AND PHYSICAL, AUGUST 30, 1978

Chief Complaint.—This 41-year-old white woman from Fenton, Michigan presents complaining of "formaldehyde toxicity" for the past four months.

History of present illness.—Mrs. Ondo was well, though she has been diagnosed hypertensive for the past four years and with chemical diabetes (asymptomatic) since December, until March of 1978 when, upon moving into a new place of employment, she and her co-workers noted a strong smell. Mrs. Ondo concurrently began to have symptoms which consisted of burning of the eyes, running of the nose, nasal stuffiness, a grabbing sensation in her throat, bronchospasm, generalized fatigue, weakness, irritability, clumsiness, double vision, dizziness, nausea with vomiting on two occasions, and progressive fatigue and depression. These symptoms, which were gradual, would be somewhat better on her days off but would return full force on her days at the office. She called in OSHA which examined the air and found it to contain toxic levels of formaldehyde. She therefore attributed her symptoms to formaldehyde, to which she was "allergic", and sought treatment for this. She continued to have her difficulty in spite of some relief with antihistamines and cortisone cream for a macular eruptive rash on her anterior thorax, but finally had to quit her job, which she did one week ago.

Since that time she has felt no better. Perhaps most disturbing is that from the period around December to the current date she has gone from 144 to 116 pounds, which she attributes to a loss of appetite.

There is no history of thinning of the hair, arthralgias, GI symptoms other than the nausea and vomiting, urinary tract symptoms, Sicca Syndrome, particular muscle group weakness, fevers, night sweats.

Of possible significance in her past history is the fact that she has a congenitally unilateral (left) kidney, and that she underwent a postpartum psychosis treated with electric shock 16 years ago. She has had no interval psychiatric difficulty. In consequence, however of her depression, she had sought help from a psychiatrist last week, who gave her a "shot" and a single tablet of elavil. Upon taking these latter she lost her equilibrium to such a degree that she fell down some stairs and bruised her legs, back and head.

PAST HISTORY

Illnesses.—Usual childhood disease. No rheumatic fever, scarlet fever, tuberculosis, diphtheria.

Surgery.—Appendectomy and ovarian cyst removal in her 20's, tonsillectomy as a child.

Trauma.—Injury to the left arm on some plate glass some years ago and the recent fall.

Allergies.—Urticarial response to penicillin and to IVP dye. No history anaphylaxis or angioneurotic edema.

Habits.—She does not smoke; she drinks rarely.

Medications.—Dyazide b.i.d.; propranolol 10 mg q.i.d. (prescribed by her DO for palpitations).

Sinequan—prescribed by her psychiatrist last week.

Travel.—None.

Transfusions.—None.

Family History.—Mother is 63 and has hypothyroidism. Father died in his 40's of carcinoma of the lung. A maternal grandmother was said to have had a cancer. Her brother, 42, is said to have hypertension and chemical diabetes. He recently had some form of skin tumor or cyst removed.

A 21-year-old sister is well. Her 16-year-old daughter is well. Her husband has a "heart condition" and is retired.

Social History.—She has graduated high school and gone partly through college. She has worked in real estate most of her life. She has recently quit her job as a real estate closure agent, as mentioned above. She, her daughter, and husband live in Fenton, Michigan.

Review of Systems—General. Weight loss as outlined. No fever, chills, night sweats.

Skin.—As described.

Head, eyes, ears, nose and throat.—She does not wear glasses and denies visual change other than the diplopia mentioned.

Neck.—Negative.

Chest.—Episodic sharp chest pains, not by symtome angina.

Heart.—She was told that she had a rapid heart rate and was placed on propranolol in June for this problem. She denies known history of MI, orthopnea, dystonia, angina, congestive failure.

GI.—Negative, save for the feeling of nausea, which has been more or less continually with her since March. She denies change in caliber, color of stool. She has had no diarrhea, blood, or pus in her stool.

GU.—During her pregnancy she was admitted to hospital with left flank pain and told she might have a kidney stone. She has no dysuria, pyuria, hematuria, no history of recurrent urinary tract infections.

She does have but one kidney—the left.

She continues to menstruate regularly, once a month, and has noticed no change in the quality or quantity of flow. She is gravida. One para; abortus 0.

Neuromuscular.—See HPI; Psychiatric see HPI.

Physical Exam.—Time: 2:00. Height: 5'4". Weight 116 lbs. Blood pressure 140 over the right arm sitting without orthostatic change; 120/100 left arm sitting. Pulse is 100-110 and regular. Respirations 12. Clinically afebrile.

General appearance is that of a wasted, tired 41-year-old woman in no acute but in evident chronic distress.

Skin.—There is a macular, papular, hyperkeratotic confluent rash on the forehead without malar rash nor erythematous rash in any other site. There are scratches, scars, and ecchymoses on the right forehead, left posterior thorax at the scapular tip, and extensively over the anterior shins, bilaterally.

Hair and nails are normal save for a slight male patterned baldness. There is no periungual capillaritis. There is no Osler nor Janeway lesion on the hand. She is anicteric with no marks of excoriation.

Nodes.—There is no palpable lymphadenopathy.

Head, eyes, ears, nose and throat.—Normocephalic with tenderness over the right frontal forehead secondary to recent trauma. There are no cranial bruits nor points of tenderness other than that mentioned. Hearing is normal to whisper and watch tick. The pinnae are normal. The tympanic membranes are somewhat retracted but have normal light reflex bilaterally. Weber is midline. Air conduction greater than bone conduction bilaterally.

There is no sinus tenderness. The nares are clear.

The tongue is midline and well papillated. The pharynx elevates symmetrically with phonation. Dentition is in good repair. There is no pharyngeal erythrema.

Eyes.—There is no conjunctival erythrema. There is good tearing. The sclerae are anicteric and without inflammation. The pupils are equal, round, and react both directly and consentually to light, and to accommodation. The fundi are normal to ophthalmoscopic exam bilaterally. Extraocular movements are full with, however, nystagmus to far right lateral gaze.

Neck.—Trachea is midline. Thyroid is soft and palpable but normal in size without bruits, nodules, or tenderness.

Carotids are 2 plus normal bilaterally without bruits. There is no cervical spinous muscle spasm or cervical spinous tenderness. The jugular venous pulse is normal.

The chest.—The thorax expands symmetrically. The diaphragmatic excursion is full and symmetrical bilaterally. The lungs are clear to percussion and to auscultation without wheezes, rals, rubs or rhonchi.

Breasts.—Without dimpling or retraction. The nipples are everted bilaterally. There is no discharge. There are no dominant masses.

Cardiac exam shows no precordial lifts. She has no palpable thrusts or thrills. The PMI is in the fifth left intercostal space 6 cm from the left sternal border. S_1 and S_2 are normal. The rate is 110. The rhythm is regular. I could hear no extra sounds, no gallops, murmurs, or rubs.

Abdomen is scaphoid with, however, a fullness in the epigastrium, right upper quadrant and left upper quadrant. Bowel sounds were normal. There was a well-healed 4 cm subumbilical midline scar of her appendectomy and cyst removal.

Superficial umbilical reflex is intact on the left and muted on the right. There is a right upper quadrant to epigastric and left upper quadrant fullness without a discreet hepatic edge nor palpable mass. The liver percusses out to about 12 cm at the midclavicular line on the right. The spleen was not palpable. There were no hepatic rubs or bruits. There was a mid-epigastric bruit.

Back.—There was no spinous or sacral tenderness. There was no sacral edema. Contour of the back was normal.

Pelvic was not done. The escutcheon was that of a normal woman.

Extremities showed no joint changes. The legs were traumatized as described. There was no clubbing. The feet bilaterally showed dependent cyanosis to the midplantar surface with prominent ¼ cm Janeway-like lesions on the distal great toe bilaterally. These were not painful to the touch. Capillary filling seemed normal. At the same time that her feet were intensely cyanotic; she showed no acral cyanosis elsewhere.

Distal hair growth seemed normal. The toenails were not dystrophic.

Carotid.—Radial, brachial, femoral, dorsalis pedes, and posterior tibial pulses were all 2 plus, normal, and without bruits.

Neurologic exam.—Mental status—she was alert and oriented, and did not seem depressed although she did seem very tired.

Cranial nerves.—2–12 were tested and were normal save for the question of to far right lateral gaze.

Muscle mass was normal. Reflexes were normal and symmetrical bilaterally without pathologic reflex.

Station and gait.—She showed some clumsiness of the left hand on finger to nose. The right was normal. She had a positive Romberg test without lateralizing fall.

Sensory examination revealed evident intact position sense in the lower extremities but a reproducible loss of vibratory sense in the lower extremities.

Impression—

1. Fatigue, progressive weight loss and question of abdominal mass.

Discussion: Obviously, this must bring up the question of a triad of an occult malignancy which went unnoticed by virtue of her attention to the irritant formaldehyde in her new position. That she had formaldehyde irritation I have no doubt, but the rash, the rhinorrhea, the eye problems, the throat and the wheezing have seemingly a past as major problems, leaving fatigue, depression, anorexia, and progressive weight loss, which may be symptomatic of another disorder: With the tachycardia, the nervousness, the depression, and the family history of thyroid disease, hyperthyroidism must, of course, be considered. The neurologic findings, if real and not induced by recent ingestion of sinequan, concurrent with possible cardiac disease, general fatigue and weight loss, might be construed to be consistent with amyloidosis. Her hypertension and carbodhydrate intolerance plus fatigue, tachycardia, and depression, might be the symptomatic manifestation of pheochromocytoma. The presence of the cyanosis of her feet is disturbing, since her distal pulses are full, and suggestive of a vasculopathic process—either a collagen-vascular disease, such as lupus, or hypersensitivity angiitis, or perhaps of a cryoglobulinemic state associated with occult malignancy. Of course, atherosclerotic disease remains entirely possible. Sub-acute bacterial endocarditis seems unlikely given the absence of fever, but must be considered in the face of weight loss, CNS disease, depression, and perhaps distal embolic or vasculopathic disease.

2. Hypertension.
3. Depression.

Plan.—I think that this woman has multiple problems which I cannot adequately work out in the Outpatient Department and that she would be well served by immediate admission to the hospital for evaluation and work-up. I shall proceed to do so. A pelvic should be done upon admission.

FAITH T. FITZGERALD, M.D.,
Director, Inpatient Programs.

AMHERST, N.Y., *May 13, 1982.*

Re social security appeals and case review process.

JOHN J. SALMON, Esq.,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

SIR: The enclosed materials might be useful to the Subcommittee on Social Security:

Report by Manfred J. Schmidt, Esq, made at the behest of the Office of Personnel Management;

Article by Robert Pear of the New York Times; and

Correspondence from the Office of Personnel Management twice rejecting my application for Administrative Law Judge.

I was a New York State Assistant Attorney General six years and all my time was occupied in litigation, preparing and trying cases in the federal and state courts.

I was a staff attorney six in the Office of Hearings and Appeals of the Social Security Administration. I was commended by my Agency for my consistent high production and excellent performance.

My experience was not sufficient to qualify for ALJ. See the enclosed letters from the Office of Personnel Management.

I retired in October 1981 from the federal service with 22 years' service. I left with grade GS-12. There was no opportunity for advancement. I entered the private sector as counsel to a corporation in the foreign trade field.

In a word, OHA lost my services of many years' legal and governmental experience. I went where there is an opportunity for advancement.

The Social Security hearing process should be separated from the Administrative Procedure Act. There is no need for formal proceedings. The Appeals Office of the Internal Revenue Service in various regions, handles cases involving millions of dollars without resorting to the Administrative Procedure Act. Indeed, the Social Security hearings are not adversary. So, why are formal hearings necessary?

If you want productivity, allow the staff attorneys to rise in a career ladder and they will do a fair job. Do not fear for their judicial and intellectual independence. Today's staff attorneys can perform as ALJ's at a moment's notice.

I have no intention of returning to government service. However, I welcome any opportunity to testify in any future hearing before your committee.

Break the hold that ALJ's have on OHA in the Social Security Administration. I have observed scores of ALJ's at close range. They are not really all that capable. Furthermore, their finished product can be reached with a less tedious and less costly procedure, and without any loss of due process.

In the public interest, divorce the Social Security hearings process from the Administrative Act.

Yours respectfully,

BEDROS ODIAN.

[Attachments]

U.S. OFFICE OF PERSONNEL MANAGEMENT,
Washington, D.C., August 14, 1981.

BEDROS ODIAN, Esq.,
Amherst, N.Y.

DEAR MR. ODIAN: This refers to the application you filed for Administrative Law Judge under the provisions contained in Examination Announcement No. 318.

Based upon the experience and qualifications factors discussed below, the score assigned to your application was insufficient to meet the passing grade of 80 established for the GS-15 grade level in this Examination. Accordingly, I regret to advise you that favorable action on your application was not possible.

A careful analysis has been made of all of the information developed in your case. The review disclosed that you met the requirements of the Announcement in terms of demonstrating the necessary length, type and level of experience. Under the circumstances, this office proceeded to develop a basic rating in your case. This rating, which is based on a scale of 100, takes into account the highest level of qualifying experience (to which as many as 60 points may be assigned) along with additional points derived from an evaluation of responses to personal inquiries relating to the applicant's professional qualifications. Based upon those two factors, the rating must equal at least 80, the grade which has been established as the passing score in the Examination. As applied to your application you received an experience score of 50 of the possible 60 points for GS-15. To this was added a score of 22 of a possible 40 points based upon an evaluation of responses to the personal qualifications inquiries. The two scores totalled 72, 8 points short of the score of 80 required to proceed further in the Examination.

You may obtain review of the final action taken by this office by filing an appeal, within thirty (30) days of the date provided above, to the Administrative Law Judges Rating Appeals Panel, Office of Personnel Management, 1900 E Street, N.W., Room 6R48, Washington, D.C. 20415.

Sincerely,

MARVIN H. MORSE,
Director, Office of Administrative Law Judges.

U.S. OFFICE OF PERSONNEL MANAGEMENT,
Washington, D.C., May 30, 1980.

BEDROS ODIAN, Esq.,
Amherst, N.Y.

DEAR MR. ODIAN: This is in response to your letter of May 19, 1980, relative to the action taken on your application for the position of Administrative Law Judge (ALJ), GS-15. You have asked for a review of the rating assigned to your application as well as details as to how the points were computed.

The rating process for ALJ applications is outlined on page 13 of Announcement No. 318 and in our notice to you of May 12, 1980. Specifically, you were assigned an "experience score" of 50 out of a possible 60 based upon the highest one-year level of qualifying experience within the seven-year period immediately preceding the date of filing in the Examination. In addition, you were assigned a "personal qualifications" score of 19 out of a possible 40 based upon an evaluation of responses received from personal qualifications inquiries directed to a number (21) of persons identified in your basic application and supporting materials. These two scores totalled 69, a score insufficient to meet the minimum passing score of 80 in this Examination.

Thus, the assigned score was not based upon a finding of a lack of qualifying experience, rather a combination of insufficient experience and personal qualifications scores.

No basis was found to warrant a change in the previously assigned rating. Please be assured that your application was evaluated in a fair and impartial manner and consistent with applicable guidelines for the ALJ Examination.

I regret that the facts of the case were such as to preclude a positive response.

Sincerely,

MARVIN H. MORSE,
Director, Office of Administrative Law Judges.

U.S. OFFICE OF PERSONNEL MANAGEMENT,
Washington, D.C., May 12, 1980.

BEDROS ODIAN, Esq.,
Amherst, N.Y.

DEAR MR. ODIAN: This refers to the application you filed for Administrative Law Judge under the provisions contained in Examination Announcement No. 318.

A careful analysis has been made of all of the information developed in your case. The review of the material submitted in support of you application disclosed that you met the requirements of the Announcement in terms of demonstrating the necessary length, type and level of experience. Under the circumstances this office proceeded to develop a basic rating in your case. This rating, which is based on a scale of 100, takes into account the highest level of qualifying experience (to which as many as 60 points may be assigned) along with additional points derived from an evaluation of responses to personal inquiries relating to the applicant's professional qualifications. Based upon those two factors, the rating must equal at least 80, the grade which has been established as the passing score in the examination. This rating procedure is outlined in greater detail on page 13 of the Announcement.

Based upon the experience and qualifications factors mentioned above, the score assigned to your application was insufficient to meet the passing grade of 80 established for the GS-15 grade level in this examination. Accordingly, I regret to advise you that favorable action on your application was not possible.

Sincerely yours,

JOHN E. FLANNERY,
Acting Director, Office of Administrative Law Judges.

[From the New York Times, Nov. 23, 1980]

ADMINISTRATIVE LAW JUDGES ARE WASHINGTON'S POTENT HYBRIDS

(By Robert Pear)

WASHINGTON.—Congress passed a Fair Housing Act in 1968 but discrimination in the sale and rental of housing has continued, in part because the Federal Government lacks strong authority to enforce the law. To remedy that defect, Congress is considering legislation to create a cadre of administrative law judges who would hear cases brought by the Department of Housing and Urban Development on behalf of aggrieved individuals. The judges could order a violator to halt discriminatory practices and could impose a civil penalty up to $10,000.

President Carter and other supporters of the bill have described it as the most important piece of civil rights legislation in years. Critics have contended that the use of administrative law judges would be an unwarranted extension of the Federal bureaucracy into the real estate industry. Implicit in all the argument is a recognition of the great power that would be vested in the administrative law judges.

The new judges are authorized in a bill already passed by the House of Representatives and pending in the Senate, where its prospects are uncertain. The judges would join a corps of 1,130 administrative law judges in 29 Federal departments and agencies. The judges are sometimes described as the hidden judiciary because they tend to get lost in the Federal bureaucracy. But their writs run the length and breadth of the land, affecting questions as diverse as the course of oil and gas pipelines, airline routes, and the licensing of drugs and pesticides.

There are 672 judges at the Social Security Administration determining eligibility for benefits, 108 judges at the National Labor Relations Board, 71 at the Labor Department and 51 at the Interstate Commerce Commission. Although President-elect Ronald Reagan has vowed to eliminate as many Federal regulations as possible, the judges will probably remain a potent force as long as the Government's basis regulatory apparatus remains in place. The judges are not subject to replacement by a new President; they can be removed only for cause.

Administrative law judges are a hybrid combining the powers of two branches of Government, the judiciary and executive. They help agencies write and enforce the regulations that carry out the statutes of enacted by Congress. Administrative law judges sort out dense, technical, economic, scientific and factual issues. Indeed, their function is often to develop a "record" of expert testimony on which to base a recommendation to the head of the agency for which they work. A trial before an administrative law judge may take several years. The judges can usually issue subpoenas and, like other Federal judges, they make findings of fact and conclusions of law.

QUESTION OF BIAS

"We work very hard without a lot of assistance," Jean F. Greene, an administrative law judge at the Environmental Protection Agency, said. "Most of us don't have law clerks. The questions we decide are terribly important." Judge Greene may determine, for example, whether a pesticide is harmful and whether its sale must be halted. In other cases, she decides whether a manufacturer may discharge pollutants into a river.

Warren E. Blair, chief administrative law judge at the Securities and Exchange Commission, said that judges there would revoke the license of a broker-dealer or investment adviser found to have violated the law in ways alleged by the commission staff.

Irving Sommer, assistant chief judge at the Occupational Safety and Health Review Commission, who has held thousands of hearings in his career at several agencies, said that administrative law judges "have taken a tremendous burden off the Federal courts."

The decisions of the judges usually can be reviewed by the top officials of the agencies for which they work. But reversals usually must be announced, with some explanation of the reasons. The route of appeal and the standards for review vary from agency to agency and from statute to statute. Private parties can usually appeal to the Federal courts.

Administrative law judges sometimes have trouble proving their neutrality and independence because the agency for which they work is often directly involved in the cases they handle. Some agencies insist on having administrative judges who once worked for the agency, and such "inbreeding" tends to raise doubts about the judges' independence. A Washington lawyer who has argued numerous cases before administrative law judges said that "many never divorce themselves psychologically from the agency they came from." Some judges "have spent their entire career since law school in one agency and have lost contact with the law in general," said the attorney, who asked not to be named. "We zealously guard our independence," insists Judge Blair of the Securities and Exchange Commission.

Some administrative law judges have suggested creation of a central pool of judges who would be affiliated with no agency in particular, but rather assigned to various agencies as the need arose. Such an arrangement would probably improve public confidence in the judges' independence, they feel, but would permit less specialization.

Most administrative law judges come from Government service. Few lawyers in private practice apply for the jobs. Because of a Government pay freeze, the maximum salary for an administrative law judge is $50,112 a year. A Federal district judge makes $54,500 and a Federal appeals judge draws $57,500.

Manfred J. Schmidt, who did a study of the selection process for the Office of Personnel Management, found that the process favored "people who know how to play the system," not necessarily those with the best qualifications. A "regulatory reform" bill offered last year by the Carter Administration would give the administrative law judges a renewable term of seven years. Many judges oppose fixed terms of any length, saying that their life tenure helps insure their independence.

A REEXAMINATION OF THE EXAMINATION FOR ADMINISTRATIVE LAW JUDGES

(By Manfred J. Schmidt)

I

"The vehicle of centralized administration employed under the Federal Administrative Procedure Act . . . (APA) to carry forward the civil service systems which the Act establishes for hearing examiner positions, has recently collapsed with a resounding thud. The casualties include the morale of the examiners in the federal administrative service, which it was the purpose of the Act to enhance. The wreckage continues seriously to obstruct the path to a sound merit system for examiners. A tolerable solution to the resulting problem can be achieved only if the best thought and effort of both lawyers and personnel administrators are enlisted in the attempt. Among those who must participate are at least some—red-faced, one hopes—who share responsibility for the disaster that has occurred." [1]

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[1] Fuchs, "The Hearing Examiner Fiasco Under the Administrative Procedure Act," 63 Harv. L. Rev. 737 (1950).

These words were written a quarter of a century ago. They were directed at the then existing problem of selecting hearing examiners—today called administrative law judges.[2] They ring as true today as when first written. The problem confronting the Federal administrative process in the selection of administrative law judges (in this paper referred to as ALJs) is today as much a matter for concern as it ever was. After almost thirty years of experience, the United States Civil Service Commission's Office of Administrative Law Judges has basically failed to alter the methods it uses for selecting ALJs. In 1955 the Hoover Commission said, "The task force carefully examined the Civil Service Commission system now used to select hearing examiners and found it to be wholly unsatisfactory."[3] Today, for many of the same reasons, and additional reasons, the same conclusion can still be drawn.

The Administrative Conference, in 1962, concluded:[4]

"Under the present practice, the evaluation is often performed by men who are not as conversant with outstanding legal work and with the real essence of what we seek in a hearing examiner as they should be . . ."

In 1974, the Civil Service Commission is recruiting ALJs without too much heed to the criticism of the past. The Commission fills empty ALJ spots pretty much as it does any other civil service position. Applicants are given an "examination", placed on a register and selected from that register.[5]

The ALJ selection process is concerned substantially with form rather than with substance. The Commission is interested not so much in what the candidate has done, as for how long and when he did it. Little emphasis is placed on how well the applicant discharged his professional responsibilities, but great weight is given the fact that while he performed them he held a specific title.

A system automatically disqualifying individuals with the talents, experience, and skills of senior attorneys, law professors and, had he lived, even the late Chief Justice Earl Warren, needs to justify itself on the basis of its inherent superiority.[6] Unfortunately, the commission's ALJ selection program is far from superior, has consistently failed to select the best, and several aspects of it violate the legally protected rights of applicants. The selection of administrative law judges is now based on meaningless rules, attracting a limited number of people, wholly arbitrary in its execution and needlessly rigid. As a result, it fails to attain the respect of the legal profession, undermines the administrative law process and does not fulfill its goal. This paper will discuss the selection of administrative law judges and the problem of the present system.

II

Ever since the enactment of Section 11 of the Administrative Procedure Act (60 Stat. 237 (1946), 5 USCA § 3501), the Civil Service Commission's selection of administrative law judges has been the subject of extensive criticism.[7]

Professor Lester of the University of Cincinnati studied the selection of hearing examiners and concluded: [8]

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[2] Hearing Examiners are referred to variously as hearing examiners, trial examiners, hearing officers, hearing commissioners; the Administrative Procedure Act calls them simply "examiners", 60 Stat. 244 (1946); in Title 5 of the U.S. Code, Section 3105, they are referred to as "hearing examiners". The Civil Service Commission's regulations now calls them "administrative law judges", 5 CFR, Part 930.201.

[3] "Task Force on Legal Services and Procedure," The Commission on Organization of the Executive Branch of the Government, 35 (1955).

[4] "Report of the Committee on Personnel," Administrative Conference of the United States, 13 (1962).

[5] Agencies select ALJs from the register, but are free to select one of the three top names, provided they do not pass over a veteran. Since names are placed on the register by score, veterans' preference and alphabetically, the non-veteran at the tail end of the alphabet has the least chance of being selected.

[6] These lawyers do not meet recency of experience criteria, CSC Announcement No. 318, p. 11.

[7] 33 ABA, J. 689 (1947); 63 Harv. L. Rev. 769 (1950); 50 Yale L. J. 422 (1950); "Appointment and Status of Federal Hearing Officers"; Report to the President's Conference on Administrative Procedure (1954); 30 Indiana L. J. 86 (1954); "The Task Force on Legal Services and Procedure," The Commission on the Organization of the Executive Branch of the Government (1955); 40 Cornell L.Q. 281 (1955); 20 F.B.A. J. 75, "Report of the Committee on Personnel," Administrative Conference of the United States (Sept. 1962); 50 Va. L. Rev. 902 (1964); 17 Admin. L. Rev. 104 (1966); 35 I.C.C. Practitioners' Jrl. 7 (1967); 19 Admin. L. Rev. 319 (1967); 25 Labor L.J. 3 (1974) Chairman Macy described the "implementation of Section 11 was a painful one for all concerned". 50 Va. L. Rev. 902 (1964).

[8] Quoted in Miller, "The Civil Service Commission's New Hearing Examiner Recruitment Program," 17 Admin. L.R. 104 (1966).

"From 1947 to 1962, the Civil Service commission had sufficient time to demonstrate that it could handle the program. It demonstrated that it could not. Midway in that period the President's Conference on Administrative Procedure in 1954 made recommendations for a refurbished administration within the Commission. The Commission was neither ready, nor willing, nor able to carry out those recommendations. A second chance may have been justified, a third is highly questionable."

In 1962, the Administrative Conference looked into the Commission's program, and it was forced to conclude:[9]

"The main limitation of the Commission as the agency to administer the hearing examiner personnel system is, in the Committee's judgment, the danger that it will fail to recognize adequately the special characteristics and needs of this particular professional group. The Commission has relied in the past too much upon its standardized policies and procedures, and has displayed too little imagination and flexibility in discovering and applying the special policies and methods necessary to recruit and develop a professional corps of hearing examiners. The hearing examiners are in many respects a unique group of professionals. The Commission has given insufficient recognition to this fact in administering its personnel program. These are serious defects . . . ."

The Administrative Conference report served as an impetus for the Commission to undertake its own study of the hearing examiner problem concluding with establishment of "new" standards.[10]

The new standards, it was hoped, would produce a better recruiting program attracting the best and brightest of potential applicants. At first blush the standards looked good, but in practice their high expectations were not borne out. Under the new standards applicants were required to show seven years of experience, two of them in the field of administrative law. A passing grade of 80 was established—before application of veterans' preference—for eligibility to appear on the register. Selective Certification was retained. Applicants who did not have an administrative law background could now substitute experience obtained in general practice. Bar admission was required for the initial appointment.

The standards went into effect in January 1964. A new recruiting program jointly launched by Civil Service Commission's Chairman, John W. Macy, Jr., and Walter E. Craig, then President of the American Bar Association, got it under way. By March 1964, 778 persons made application and of them 80 (about 10 percent) were placed on the register. This was testimony more to the fact that the program continued to be arbitrary and rigid than of its abilities to screen the most able. ALJ recruitment program today has a narrow appeal. The Administrative Conference, in its study of the Commission's ALJ recruiting program, found that "about 70–80 percent" of the ALJs appointed "never held other than Federal employment" and "over 50 percent spent their entire professional career in one particular agency."[11] Similar statistics would prevail today should another study be made.

Federal employment should not be a bar to an appointment as an ALJ. But the cited statistics indicate that those who are actually appointed do not represent the legal community as a whole, strongly suggesting a parochial group from which applicants are drawn and giving rise to legitimate concerns that not always the best and brightest are attracted.[12]

The changes that have taken place in the Commission's administration of Section 11 of the APA fail to reflect much of the valid criticism that has been and that is currently being lodged. Unless the Commission, on its own, revises its ALJ program, the chance that sooner or later it will be done under pressure of a court order becomes increasingly more a reality. There still is no strong drive to attract members of the Bar generally. The Commission's recruitment program continues to operate basically as an in-house program, offering a place for agency lawyers who have no place else to go.

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[9] "Report of the Committee on Personnel," Administrative Conference of the United States, 27 (1962).

[10] To assist the Commission in evaluating what it was doing it appointed an advisory committee consisting of:

The Commission's Executive Director, Warren B. Irons, its General Counsel, L. V. Meloy, its Director, Office of Hearing Examiners, Wilson M. Matthews; Frank W. McCullough, Chairman, National Labor Relations Board; John H. Warner, General Counsel, Civil Aeronautics Board; J. Forrester Davison, Professor, George Washington University, School of Law; Paul N. Pfeiffer (succeeded by Leo M. Pellerzi) President, Federal Trial Examiners Conference; and L. H. Axman and Valentine B. Seale, attorneys in private practice.

[11] "Report of the Committee on Personnel," Administrative Conference of the United States, 18 (1962).

[12] Miller, "The Tangled Path to an Administrative Judgeship," 25 Labor L.J. 11 (1974), Von Rinteln, "Hearing Examiner Recruitment and the Government Lawyer," 35 I.C.C. Practitioners, Jrl. 7 (1967).

III

The ALJ recruitment program starts with Civil Service Commission Announcement No. 318. This Announcement is the official Civil Service Commission publication containing all the requirements lawyers must meet to qualify as ALJs. Here is the source for the official instructions available to applicants on what must be done and how it is to be done.

Laymen and lawyers alike, however, will have a difficult time reading this Announcement since it is written in the typical Government bureaucratize style. Announcement No. 318, like so much of what the Government writes, is cumbersome and difficult, as the following example shows: "An applicant, at the time of filing must be, and for a period of at least 7 years, must have been, duly licensed and authorized to practice as an attorney under the laws of a State or the District of Columbia, the Commonwealth of Puerto Rico, or any territorial court established under the Constitution." This sentence is simply saying: An applicant must have been admitted to the Bar for at least seven years.

All too often, the sentences in the Announcement are long and complicated, obscuring their meaning. The writing contained in the Announcement fails to follow Robert Louis Stevenson's admonition—"hard writing makes for easy reading." A complete revision—without changing any of the substantive material—will create a more favorable impression as well as dispel much of the confusion associated with Announcement No. 318. To the Commission and to civil servants, terms like "examination" and "register" are words that have a special meaning. To the unitiated, they take on their ordinary meaning and are not understood for what is intended. The non-government type does not think of a "register" as a list of individuals who are qualified for government employment. Similarly, no one things of an "examination" as meaning a resume, or curriculum vita, yet, that is what it means in Announcement No. 318.

Although the foregoing is a rather minor point, it is the source for the unflattering image that many people have of the ALJ recruiting program and shows why as a recruiting bulletin it fails to do the best job possible. Announcement No. 318 deprives the Government of potentially good applicants.

Edward B. Miller, Chairman of the National Labor Relations Board, wrote letters to a number of potential applicants surveying them as to why they failed to follow through on their application after showing an initial interest in becoming ALJs.[13] According to Chairman Miller, more than 30 percent of his respondents stated that they lost interest because of the "cumbersome nature of the application selection and procedures." A rewrite of the Announcement would have forestalled some of this.

Announcement No. 318 imposes a great burden on the applicant. He must reconstruct his career on paper and submit it to the Commission. For the busy practitioner, who has had a long and varied history of experience, the task is enormous. Records may frequently not be available to him so he must reconstruct every case from memory. This is particularly true of practitioners who have moved from one geographic area to another or from job to job or who do not have access to court files to assist them. The candidate with the least experience can easily magnify it, and because of his meager background, he recalls everything. The applicant with the most varied and most complex background has the toughest job and for that reason often looks less impressive on paper than the former.

An applicant, to begin with, must demonstrate he is a member of a Bar and has been for at least seven years prior to filing. He must show that he has in the aggregate, at least seven years of experience, in one of the following:

A. Experience as judge, master, or referee of a court of record; or

B. Experience as head (or one of the heads) of a governmental regulatory body, responsible for (1) conducting, or supervising the conduct of, formal hearings and (2) making decisions on the basis of the record of such hearings; or

C. Experience in a governmental regulatory body as an officer or employee presiding over formal hearings and making or recommending decisions on the basis of the record of such hearings; or

D. Experience in the preparation of cases for, or their presentation at formal hearings conducted by governmental regulatory bodies or court proceedings relating thereto (an applicant will receive credit for participation in the preparation of a case only if he shows that he was either solely or jointly responsible for determining whether the preparatory work is acceptable for use); or

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[13] 25 Labor L.J. 5.

E. Experience in the preparation of cases for and their presentation at trial in courts of record of unlimited and original jurisdiction or the preparation and presentation of appeals therefrom; or

F. Experience in the active professional supervision and direction of subordinates engaged in functions described in Category D above; or

G. Experience as a responsible official in a governmental regulatory body, whose duties require him to (1) review, analyze, evaluate, and recommend action to be taken by the head (or heads) of the body on decisions or recommended decisions on cases made by hearing officers on the basis of the record of formal hearings, or (2) render responsible assistance to the head (or heads) of the body in the preparation for, or hearing of, cases coming for a formal hearing before the head (or heads) of the body, or in the preparation of decisions by the head (or heads) of the body on such cases.[14]

These requirements impose frustrating and meaningless demands upon applicants. For example, in paragraph D the Commission requires attorneys claiming experience based on participation in regulatory hearings to show they participated "in the preparation of cases for or their presentation at formal hearings . . ." On the other hand, courtroom attorneys must demonstrate they participated in "the preparation of cases and their presentation at trial . . ." (paragraph E). In other words, attorneys claiming experience based on their work in a regulatory agency need show only preparation or presentation of a case; attorneys relying on court experience must show both preparation of cases and their presentation. An attorney working in the Antitrust Division of the Department of Justice must show that he tried and that he prepared a case. An attorney working on a similar or even the same case, while it was before the Federal Trade Commission must establish only that he presented the case or that he prepared the case, but not both.

These differing requirements, the and/or dichotomy, are meaningless. They are entirely arbitrary and serve no purpose other than aiding attorneys who practice before the administrative agencies. By thus favoring the administrative attorney, the Commission demonstrates a woeful lack of knowledge. A judicial proceeding is more formal that an administrative proceeding. The administrative law judge has no bailiff to enforce order and to constantly remind and to serve as a symbol of the court's dignity. The spaciousness of the courtroom, in and of itself, often can be an awesome thing, particularly when contrasted to the facilities agencies have available. These differences illustrate why the courthouse lawyer must operate in a formal atmosphere that demands alertness and skills of the highest calibre.

There are also substantive differences between administrative and judicial proceedings. The rules of evidence are not strictly applied in administrative hearings. No administrative attorney needs to distinguish between the various hearsay exceptions; whether a presumption constitutes evidence; or what the jury may here. Administrative proceedings do not involve Federal Rules of Procedure or anything comparable. Administrative pre-trial, if used at all, is a simplified version of what trial attorneys must understand. The administrative attorney rarely encounters legal problems involving production, interrogatories, admissions, or depositions. He rarely has to evaluate whether statements made at a settlement conference admissible. No courtroom attorney is a stranger to these matters.

The difference between what the courtroom attorney must be prepared to deal with and with what he does as compared to an administrative practioner, are substantial. Yet, the courtroom attorney to qualify as an ALJ must show he prepared and presented a case; the administrative attorney meets the requirements by showing only preparation or presentation. By continuing to retain the and/or dichotomy it is almost as if the Commission were saying experience gained while performing on-the-job training counts as qualifying experience, but doing the job itself does not count.

In addition to demonstrating that he has the requisite experience and that it is recent, a candidate must demonstrate that he has gained some of that experience within two years of the application date, and he must establish the quality of that experience. Thus the Announcement No. 318 states: [15]

"An applicant must have had progresssively responsible experience which demonstrates his ability to conduct hearings in a dignified, orderly, and impartial manner; determine credibility of witnesses; sift and analyze evidence; apply agency and court decisions; prepare clear and concise statements of fact, law, and order; and exercise sound judgment. Finally, an applicant must conclusively demonstrate that he has the judicial temperament and poise required for successful performance in a judicial or quasi-judicial position."

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[14] Announcement No. 318, p. 5.

[15] Announcement No. 318, p. 4.

Undoubtedly, these are the qualifications every judge strives for but in truth it must be admitted, few attain. While no one will quarrel that these are worthwhile goals the Announcement fails to note how the applicant may demonstrate he possesses them, nor how the Commission proposes to evaluate these characteristics if evidence of them is submitted. One can only assume the Commission knows what is meant by "conslusively demonstrate that he . . . [the applicant] has the judicial temperament and poise required for successful performance in a judicial or quasi-judicial position." Applicants cannot possibly respond to this requirement in a meaningful manner, nor does the Announcement offer any assistance. These requirements are a goal; they are not qualifications. The presumption that applicants can demonstrate these characteristics ignores realities. An earlier critic, writing about this aspect of the Commission's examination, said: [16]

The factors which are "rated" in determining the percentage grade of each applicant for the hearing-officer register embrace the value of this professional experience in relation to the work to be done and his ability in various respects of which the following are typical: ability to analyze and evaluate evidence, ability to interpret and apply law, ability to make independent decision in important matters, ability to write clearly and concisely, ability to be objective and free from influences which might affect impartial judgment, and ability to preside at and control meetings, conferences, and hearings with dignity and poise. No written test is given; but experience reflected in the applicants' records is evaluated and their relevant qualities are appraised on the basis of correspondence or interviews with references, former employers, associates, etc., and on the basis of an oral interview which concludes the examination.

It is obvious that mathematical exactness in the grading of intangible factors such as the foregoing is unattainable. The most that can be hoped for is that the grades assigned shall reflect as well as possible "sensed qualitative differences" in the factors measured. Because of inescapable error, the resulting rank-order of eligibles reflects only imperfectly the relative merits of those listed. The choice which agencies have among the highest-ranking three hardly counteracts the probable errors. *The question arises, therefore, whether a method that leads to these errors can be justified.* (Emphasis supplied)

The commission has resisted all changes in this vein. Instead, it has clung to its system of evaluating applicants, although totally biased and completely subjective. It places great weight on these subjective error-filled and non-measurable characteristics. The Hoover Commission characterized the Commission's recruitment as:[17]

". . . Machinery [which] has been shown to be impersonal and cumbersome. Many personnel procedures are unnecessarily complicated, and the rigidity of certain of them does not permit the necessary latitude of judgment and discretion that operating officers need to do the most effective management job."

Since 1949, when this criticism first was made, the Commission has done little in response to it as it pertains to ALJs.

Announcement No. 318 sets up narrow and rigid standards and it allows no exceptions. For example, applicants claiming experience in "routine misdemeanors, probate, domestic relations, minor tort matters, and cases of a similar nature" may not count this work as part of their qualifying experience.[18] The blanket exclusion of any experience serves no useful purpose. True, not every case is a "big case", but as to what is and what is not, must be based on the case and not the type of case.

Some probate and domestic relations matters are very complicated and are far more involved than anything counted as qualifying experience. Announcement No. 318's outright rejection of certain types of cases and its failure to evaluate an individual's qualifying experience as measured by what he actually has done, rather than the type of case he worked on, continues to make applicable the criticism that the Commission's ALJ selection procedure lacks the "necessary latitude of judgment and discretion that operating officials need to do the most effective management job."[19]

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[16] Fuchs, "The Hearing Officer Problem-Symptom and Symbol." 40 Cornell L. Quarterly 281, 312 (1955).

[17] "Concluding Report," The Commission on the Organization of the Executive Branch of the Government, 18 (1949).

[18] Announcement No. 318, p. 5.

[19] Concluding Report, supra at 18.

To get fully qualified ALJs, it is far more important that the Commission ascertain what was done and how it was done, than simply know that it was done. The Commission's rejection of experience—based on the type it was—without examining that experience, does not serve the interest of securing the ablest and most qualified candidates. Simply examining an applicant's general background tells little about him. The practice should be to probe into the details of his work. If this were done no class of cases would have to be excluded.

Applicants may meet the Commission's criteria and satisfy the seven-year standard as well as the recency of experience demand, and yet actually they may have very little real legal experience. Simply to have worked for a given period of time tells very little about the quality of a candidate's work. This aspect is largely ignored by the Commission. The Commission's instructions to its examiners ignore quality entirely. These instructions discuss titles, courts in which the work is performed, but the quality of that work is not discussed.

Furthermore, the Commission's staff is ill-equipped to look into a candidate's quality, both based on their own background and the size of the staff. It is very doubtful the Office of Administrative Law Judges, as presently constituted, has lawyers with the type of background that properly can evaluate a candidate's experience. For too long the Commission has ignored the admonishments that "it does not possess . . . on its regular examining staff lawyers of sufficient stature to pass judgment upon the experience and qualifications of applicants for a small number of positions near the top of the governmental legal hierarchy."[20] The examiners now employed in this function, without meaning in any way to slight their talents as examiners, are not recognized as lawyers of stature and, indeed, some are not even members of a Bar. Those who are have a limited background as trial lawyers. While there is nothing sacrosanct in having experienced lawyers make the evaluation of the applicant's skills, lawyers familiar with trial work bring to it insight, based on experience which gives them that subtle touch now lacking. This background, it is submitted is required for evaluating the quality of a candidate's work. In order for an applicant to establsh that he has two years of administrative law experience, Announcement No. 318 requires each candidate to list the cases he worked on, in chronological order and supply the following:[21]

1. Title and citation;
2. Dates between which participation took place;
3. Brief statement of issues involved;
4. Regulatory body or court hearing case. Note: For each court so cited, indicate whether Federal, State, or local; extent of jurisdiction (limited or unlimited), original or appellate);
5. Number of workdays spent in handling case, and in what capacity, i.e., judge, attorney, etc.; and
6. Names and current address of:
   (a) Hearing Officer of regulatory body or of judge who heard case;
   (b) Co-counsel, if any;
   (c) Opposing Counsel; and
   (d) Names of Counsel appearing in case if applicant claims qualifying experience in a judicial type position.

Listing each case, in the Commission-required manner, tends to make the most insignificant case sound important. The Announcement fails to ask any crucial facts that would enable the Commission to carefully evaluate an applicant's experience. The facts that are solicited are but a mass of statistical information as far as quality of experience goes.[22] While this method of securing information permits a rapid check-off system to be used, and that perhaps explains why it is employed it provides little substantive insight about a candidate. The information requested suggests the Commission is more interested in form rather than substance; it tells something about the Commission's examiner-lawyers.

As the leading personnel agency in the country, perhaps in the world, one expects more from the Civil Service Commission. The current trend is to make job descriptions realistic; to remove arbitrary barriers and to evaluate an applicant's skills, in terms of the position to be filled.[23] The Commission's responsibility requires more than a casual business-as-usual attitude. It is, after all, the Commission that has taken over a leading role in the area of employment practices and holds itself ready to impart its know-how to others.[24] In view of these considerations, the artifical and meaningless requirements of Announcement No. 318 should be removed so at least the Commission may lay claim to its own preachings.

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[20] 63 Harv. L. Rev. 765 (1950); See also: Fuchs, "The Hearing Officer Problem—Symptom and Symbol," 40 Cornell L.Q. 281 (1955).

[21] Announcement No. 318, p. 11.

[22] The author knows of cases where the Commission required additional information such as the address of the United States Court of Claims (which, of course, is Washington, D.C.); the necessity for this request speaks legions for the examiner's imagination and comprehension.

[23] See: Emergency Employment Act of 1971 (PL 92-54 (1971)).

IV

The most controversial aspect of the Commission's ALJ recruitment program is its rating of a candidate's application. In attempting to evaluate future ALJ's, the Commission is faced with an acknowledged difficulty. Its goals are clear: the selection of the most able and best qualified from a field to highly competent individuals. Few critics are willing to acknowledge that the Commission is succeeding in its goals; some claim the Commission is getting only the "not so talented."[25]

While it may be disputed as to whether the rating process selects only "outstanding" lawyers, it is, nevertheless, clear that the Commission, in rating applications, is guilty of numerous inconsistencies, is arbitrary, and, taken as a whole is doing an admittedly difficult task in a wholly unacceptable manner.

Applications are rated under a schedule divided into two parts. Under the first part, Part A, an applicant may earn a maximum of 60 points. An applicant is entitled to 40 additional points under Part B. Under Part A an applicant earns a range of points depending on what he has done, based on his grade (Government GS grade), his title (Assistant Attorney General, Section Chief, Justice of the Peace, etc.), or the Court in which he practices. (District Court, Court of Appeals, etc.). On the basis of these factors he earns up to 60 points. Up to 40 points for Part B are awarded based entirely on the confidential inquiries—the Commission calls them vouchers—sent to a list of individuals selected by the Commission to evaluate the candidate. Upon completion of the Commission's rating, an application is assigned a numerical score; eighty (80) or better is passing. This final score has little relationship between an applicant's experience and background; it is based 40 percent on the confidential inquiries and 60 percent on his title, pay and what he was assigned to do; not what he did.

The Commission admits "There are no magic formulae or set rules that can be used in performing this task."[26] Under recent court rulings, the Commission's failure to relate the scoring of the application to the job, raises question as to the legality of its practice. *Griggs* v. *Duke Power Co.*, 401 US 424 (1971). Aside from *Griggs*, the Commission's rating is a wholly arbitrary system, badly in need of revision.

The Commission provides its examiner with instructions on how to rate each candidate's application. This information is contained in the Rating Schedule. It starts by assigning an alphabetical letter to the various jobs the applicant may have held in the past. The letters have a numerical value: "A" is 60 points; "C" is 55 points and "E" is 50 points.[27] The following listed jobs are assigned values: Hearings Examiner (A); Federal Regulatory Agency Members (A); Members of Federal Boards of Tax Appeal (A): Judges of State Courts of Appeal (A or C); Private Law Practice (C or E). All together, 22 different jobs are listed and assigned letter values. The rating schedules also contain a list of different courts based on Martindale & Hubbel. Each court is rate "A", "C" or "E" and an applicant's experience is rated, depending on the value assigned each court according to where the Commission believes he predominantly practiced. The rating schedule makes no allowance for the different kinds of cases an applicant may have tried. A multi-party suit or a class action is rated no different from a simple breach of contract suit. All that counts is the title of the applicant and the court in which the action took place.

A careful reading of the instructions fails to disclose that the Commission actually explores the work an applicant did and its relationship to the numerical value assigned under Part "A". No effort is made to measure individual experience. The rating schedule is limited to the job categories and the place where the litigation took place (type of court). Not one word in the rating schedule refers to trial experience. How well was the case tried? How difficult and novel was the issue? How complex was the matter? In part "A" these matters are not measured. Of course, a candidate is free to submit "independent evidence", but the rating schedule provides no instructions for measuring it, and in light of the specific instructions it is doubtful that more complex matters handled by an attorney GS-14, for example, will be considered and cause the examiner to increase his score based on that. The rating schedule is not geared toward measuring experience. What the candidate did in court is *not* rated, and the quality of an applicant's experience is of seemingly little concern to the Commission.

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[24] See: Intergovernmental Personnel Act of 1970 (PL 91-648 84 Stat. 1909 (1971)); See also: The Commission's Proposed Uniform Guidlines in Employee Selection Procedures.

[25] 25 Labor L. J. 11.

[26] Rating Schedule, Competitive Examination for Hearing Examiner, GS-935-15 & 16, U.S. Civil Service Commission, Supplement No. 2, page 2 (1970).

[27] Why it is necessary to convert to an alphabetical letter whose numerical value is used, is a mystery. A more simple method would be to assign numerical values initially.

The rating schedule confuses the examination process with the classification process. It very accurately measures the capacity in which a candidate has done something and where he has done it. It fails to examine what he did. It classifies a candidate. Classification, however, is no substitute for examination. Classification fails to measure what it is an applicant did and how well he did it; it is not adequate for selecting an ALJ. Selecting an ALJ on the basis of the fact that he appeared in the Supreme Court of his State as an Assistant State's Attorney General demonstrates little about his skills. The Commission ought to know what a candidate did and how well did he do it, as well as how often he has done it. At present the rating schedule ignores the quality of the applicant's background entirely in favor of nonqualitative characteristics.

The rating schedule, as does the Announcement, carries forward the and/or dichotomy. Thus, supervisors of administrative lawyers get credit for their supervisory work, but supervisors of courtroom lawyers must demonstrate they "personally prepared *and* tried cases." Supervision alone is "not creditable" for courtroom lawyers.[28] Another meaningless distinction, and one that is inherently unfair, is that a supervisor of an administrative attorney is given credit for the work performed by the lawyer he supervises. If, for example, lawyer "A" (Grade 14) is supervised by lawyer "B" (Grade 16), the rating schedule allows the examiner to give lawyer "B" 60 points for the work performed while he supervises lawyer "A". The examiner assigns 60 points to lawyer "B" without ascertaining what he really did, aside from his supervision. The fact that lawyer "A" may always have been right and that lawyer "B" decided everything wrong makes no difference. It matters not what was done; it matters only *who* did it. Again, the classification concept has crept into the examination.

Private practitioners are limited to a "C" or "E" rating; the government attorney may be rated "A", "C", or "E", depending on his *grade*. A government attorney, Grade 16, will receive an "A" for a case, while his opposing counsel from private practice is limited to a "C" or "E" rating. The case that is tried (the accomplishment) is ignored entirely. Among those dealt with most unfairly are government attorneys in Grade GS-14. This class of attorneys is assigned only 50 points, based on their grade of GS-14. The quality of their performance means nothing. As a result, a Grade GS-14 has a 10-point disadvantage compared to a Grade GS-16 and a 5-point disadvantage compared to a Grade GS-15. The Grade GS-14 can attain no more than 98 points in an examination that has a passing grade of 80. A Grade GS-16 simply because of his grade gets 60 points; a Grade GS-15 gets 55 points. It matters not what the nature of their experience was, nor does it count how well they performed. No inquiry is made into their actual work; they get their points based on their grade. Considering the fact that a host of journeymen attorneys are at the level of a Grade GS-14 and qualify otherwise to become ALJs, this disadvantage penalizes some of the potentially most qualified applicants. Similarly, many Grades GS-15s or GS-16s who, had they been GS-14s, would not qualify as ALJs.

The arbitrary assignment of points tells the Commission very little about the candidate; it tells the Commission nothing new about how well an applicant will perform as an ALJ. The assignment of points by reason of the position held, not the experience gained, will not select the most qualified. This system produces bodies, but not skilled ones, since skill is not a selection standard.

V

"In the case of each applicant who is found to have clearly met the requirements of this Announcement, confidential inquiries will be sent to a number of individuals whose names were furnished to him; confidential inquiries may also be sent to other individuals selected by the Commission."[29]

In this manner, the Announcement introduces the second phase of the Commission's examination. Chairman Edward B. Miller of the National Labor Relations Board found that sending out these inquiries to lawyers presented a variety of practical problems.[30] The lawyers in active practice that were surveyed by Chairman

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[28] Rating Schedule, Supplement No. 2, p. 1.
[29] Announcement No. 318, p. 13.
[30] 25 Labor L.J. 11.

Miller did not want to be placed in a position where it became known they were "out looking". The Commission sends the inquiries on its own; the candidate has no knowledge of what the Commission does. This practice has caused at least one responding party to down-rate a candidate because he had not been informed by the candidate that he would be asked to furnish a reference.[31] While for many people it may not be a problem having an employer know that a job change is contemplated, to others this may be a serious matter. The Announcement states that any applicant that does not permit the Commission to make confidential inquiries of his supervisor or partners or associates, will have his application cancelled. This is a high price to pay for privacy and the right to submit an application. It seems the Commission could easily delay sending confidential inquiries until the very end of the qualification process, thereby enabling the applicant to preserve his privacy and his job if he fails to become an ALJ.

The confidential inquiries consisting of a form letter (CSC Form 192) are sent to references furnished by the applicant or to anyone the Commission deems has appropriate knowledge about the candidate such as a supervisor, opposing counsel or judge. Respondents are asked to compare the candidate with other people they have known who have the same amount and type of training and experience, not to other applicants. They are also asked whether they have "daily", "frequent", or "infrequent" contact with a candidate and in what capacity they know him.

The information furnished to the Commission is held in confidence, hence the name "confidential inquiries". The form letter lists eleven categories to which the addressee (respondent) is asked to reply by checking boxes headed as follows: "No Opportunity to Observe", "Less Than Adequate", "Adequate", "Better Than Adequate", "Outstanding".

The responses received by the Commission are also evaluated on a numerical basis and assigned a maximum of 40 points. These 40 points, plus the 60 points (the maximum possible under Part "A") give a candidate his aggregate score (100). As will be demonstrated herein, however, Part B really controls whether an applicant is placed on the register or not.

An attempt is made through the confidential inquiries to investigate a candidate's professional background. The respondent is unknown to the Commission. Equally unknown to the Commission is his relationship with the candidate. He may be thoroughly familiar with the candidate or he may have scant recollection of even his name. Similarly unknown to the Commission is how each respondent approaches his task. One respondent may make a sincere effort to evaluate a candidate; another may check the first convenient box; a third may simply give it to his secretary to complete. The Commission has no way of knowing what was done. It makes no effort to distinguish between responses received.[32]

The questions posed in the "confidential inquiry" raise issues to which the closest associate or most critical teacher will have a hard time responding objectively. For example, in part, each respondent is asked to evaluate and to rate a candidate on the following: analyzing and evaluating evidence; interpreting and applying laws, rules, regulations and legal precedent; writing statements of fact and law; recommendations and orders; securing facts from individuals through observation and interviews under difficult conditions; handling difficult situations when presenting or preparing cases; presiding at meetings, conferences or hearings; making independent decisions in important matters, objectivity, and professional standing. Under the best of circumstances the Commission has delegated to the respondent a difficult task. Respondents are asked to compare the candidate with other people they have known who have the same amount and type of training and experience, not to other applicants.

The Commission acknowledges that no absolute standard exists for measuring the confidential inquiries it receives from the respondents. Each respondent, depending on his own background, totally unknown to the Commission, must make an independent evaluation. It would be futile for the Commission to assume that these replies are objective or in any way uniform. No two respondents will approach this task in the same way, and no two responses will be the same. Yet, the Commission places great reliance on these responses or "vouchers" as they are called by the Commission. They make up 40 percent of an applicant's grade and control 100 percent whether he succeeds or not. No allowance is made for the hard marker or the easy marker. The Commission has no way of knowing whether a voucher was completed in 30 seconds, or 15 minutes; whether the voucher was completed by an attorney or his secretary; whether the respondent is a close friend of the applicant or his worst enemy.

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[31] *Ibid.*, p. 11.

[32] The Commission does call one group of responses "controlling witnesses" and attaches more importance to their comments but has no knowledge as to the reliability of the "controlling witnesses" comments.

The Commission divides respondents into two categories; those that are "controlling witness", and those that are not. A controlling witness is one who "because of his stature, the nature and extent of his relationship with the applicant and the recency of his observations, is best able to furnish a reliable, well-balanced evaluation of the applicant." [33] The information furnished by a controlling witness, the Commission states" . . . definitely should be given prior consideration and heavier weight." [34] If an applicant has the good fortune or bad luck of having as an opponent, a judge, co-worker, or supervisor, one who is someone of "stature" it can make a difference; it will also make a difference whether his relationship with this person is a good or bad one. What will not make a difference is whether the "controlling witness" even knows the candidate, has a bias, or had his secretary complete the voucher (which is reasonable for someone of "stature").

Stature should not qualify a respondent to the extent that his response is given "heavier weight". Unless the Commission can demonstrate that there are circumstances justifying treating one witness "heavier", all witnesses must be considered the same. The idea that "stature" makes him more knowledgeable about an applicant's professional qualifications is questionable. Even one's supervisor may have little knowledge about some of the areas of inquiry. The dissimilarity between how each respondent approaches these vouchers and their knowledge concerning the candidate should raise questions as to their reliability and usefulness. To the Commission, however, they are the capstone of the examination. A failure to earn enough points in the vouchers is a failure of the whole examination.

Evaluation of the vouchers is termed "profiling" by the Commission. The evaluation of a candidate's career up to this point is a highly subjective process; as a result of "profiling" the evaluation made becomes totally unreal.

The Commission readily admits that "profiling"—which really means the individual gets on the register or he does not—is a subjective process. The Commission's instructions to its examiners state: "There are no magic formulae or set rules that can be used in performing this task." [35]

It is doubtful whether magic is what should be used. It might be an improvement over what is done but applicants have a right to expect a non-subjective consistent evaluation to be made and points assigned to them based on valid standards. The Commission, unfortunately, fails to do this; nor does it appear to comprehend the task at hand the inconsistencies and the arbitary nature of "profiling" suggests a failure to appreciate what is involved; the importance of the individual applicant's rights and the unjust impact of its cavalier decision. All of this strongly suggests a denial of any due process in the selection of ALJs. *Greene* v. *McElroy,* 360 U.S. 474 (1958); *Wilner* v. *Committee on Character,* 373 U.S. 96 (1963); *Holmes* v. *N.Y. City Housing authority,* 398 F2d. 268 (2nd Cir. 1968); *Thompson* v. *Gallagher,* 42 L.W. 2383 (5th Cir., Dec. 18, 1973).

The vouchers and their rating by the Commission's examiners reduces itself to a highly subjective process based on misleading and inconsistent instructions. To begin with, the Commission does not know, and the examiner is not told, how a voucher shall be scored. Although the Commission provides examiners with detailed instructions (including the color of the lead in his pencil), these instructions do not tell an examiner to assign a fixed score that assures that each voucher, no matter who evaluates it, adds up the same way. The score assinged to a voucher is left to the examiner with the result that no two examiners will rate any two vouchers the same way and in all likelihood will not rate the same voucher the same way at different times. The individual items appearing on the vouchers are divided into four sub-groups (Groups I, II, III and IV). The columns "Outstanding", "Better Than Adequate" and "Adequate", are assigned a range of points. On the basis of no fixed policy or stated formula, an examiner is free to assign points on the basis of how he "evaluates" the vouchers. The four categories are further divided into sub-categories. Thus, under *Analyzing and Evaluating Evidence* there are two sub-groups: "a) Thoroughness in analyzing all items of evidence presented in a case rather than tending to accept some of the items at face value", and "b) Ability to distinguish relative value of items of evidence in the record."

A table of points is found in the Rating Schedule, page 8 as follows:

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[33] Hearing Examiner Rating Scheduled, Supplement No. 4, p. 2.

[34] Ibid, p. 2.

[35] Rating Schedule, Supplement No. 4, p. 2.

	Outstanding	Better than adequate	Adequate
Group I	10–16	5–9	0–4
Group II	8–12	4–7	0–3
Group III	6–8	4–5	0–3
Group IV	3–4	1–2	0
Total points	27–40	14–23	10

The respondent may check several columns ("Outstanding", etc.) for each subgroup. The examiner has the task of assigning points according to where the checks fall. It is reasonable to assume that a respondent in placing his checks assign relative values to each sub-category as does the examiner. Each does it subjectively. The values each assigns, however, are not going to be the same and the scoring is not going to reflect what the respondent intends. This further illustrates how the result fails to measure realistically anything about the candidate.

The instructions state: "It requires . . . a weighing of the relative values of witnesses' testimony and an application of the examiners' judgment."[36] Thus, if all or most of the respondents have checked "Outstanding", the examiner, using his judgment, nothing else, assigns a numerical value ranging from 27 to 40 points.[37] The use of the terms "testimony" and "witness" is misleading, particularly since what "testimony" there is, is in the form of a piece of paper and the witness is a name on that paper. The Commission's instructions give the appearance of a trial (implying fairness); nothing about the process is fair in view of its total lack of objectivity.

It is worthwhile to recall at this point that the vouchers are the reflections of what some 20 people think of a candidate. The examiner's evaluation compounds what has been done, producing a result that is worthless, because it amounts to nothing more than an opinion by an examiner of what he believes the respondents' opinions are concerning the candidate. The system is simply an arbitrary method of assigning points and there is no excuse for its continued use. With little effort the Commission could make any number of changes that would eliminate some of these faults.[38] Why the Commission continues to use "profiling" is a mystery.

Respondents are never informed of the importance of the task assigned to them, nor are they furnished information on how the vouchers are evaluated. They have no knowledge as to the significance of what they are doing. The respondent is never told how the information furnished is evaluated, but it is mathematically demonstrable that unless the respondent checks only the column headed "Outstanding", no candidate, other than those scoring 55 in Part A (a minority, no doubt), will attain the minimum points required to place him on the register. Von Rinteln characterizes this scoring similar to the "sudden death" playoff of professional football.[39] Here is how it works: Candidates, under Part A are given 50, 55 or 60 points on the basis of their "experience". This means the candidates must attain 30, 25, or 20 points in part B to reach the qualifying 80 points. If a candidate scores 27 points in Part B, which the Commission acknowledges makes him "Outstanding", he will not be placed on the register if his score under Part A is only 50 points (the maximum for a GS-14 government attorney).

The fragility of the system is underscored also by the fact that since the maximum points available are only 23—if any column other than "Outstanding" is checked—only a candidate with 60 points under Part A can attain 80 or better. The anomaly of the scoring process is the candidates that may be the least qualified under part B pass. This is so because under Part A 60 points are awarded automatically to all GS-16s. Therefore, this candidate, even if he attains only 23 points—better than Adequate, but not Outstanding—under Part B attains an aggregate score of 83 and passes. Yet, the GS-14 (or counterpart in private practice) who is rated 27 points under Part B—Outstanding—is failed as his score can only aggregate 77 points, 3 points less than the required 80 points.

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[36] Hearing Examiner Rating Schedule, Supplement No. 4, p. 2.

[37] One wonders if the Commission grades all its examinations so subjectively. Would it not be important in the selection of one of the most important positions filled by the Civil Service Commission to reduce subjectivity to a minimum?

[38] The Commission could adopt a pass/fail system, could assign fixed numerical points to each column, so an examiner and respondent would know the numerical value; could do away entirely with the vouchers; replacing them with an investigation by experienced trial attorneys; assign it less importance; etc.

[39] 35 I.C.C. Practitioners Jrl. 14 (1967).

The point-spread assigned to the vouchers is so narrow, the differences between the candidates that pass and the ones that fail is too infinitesimal a pass or fail system would serve just as well and have the added advantage of eliminating the examiners' grading of the vouchers, which only adds to the subjective evaluation made.

The present system leaves more to chance than to design. A quick check of "Outstanding" by a busy lawyer means success for one candidate, and anything less dooms him to failure. It is doubtful that the lawyer who checks "Better Than Adequate" or "Adequate" intends to disqualify a candidate, and thereby deprive the Government of an opportunity to select many of the ablest lawyers. Finally, it is very doubful that *any* two attorneys responding to a voucher define its terms the same way.

Some lawyers, however, are aware of the system and use it to the Commission's disadvantage. The lawyer who works in a government agency, who has daily contact with his colleagues, who lunches with the hearing officer, who is constantly bombarded with requests for favors from the private sector, can let it be known he is considering becoming an ALJ and that a rating of "Outstanding" is mandatory if he is to succeed. He is confident his friends and colleagues will not let him down. On the other hand, the busy attorney, who handles numberous cases before judges to whom he is only a name, and opposing counsels who are competing attorneys in the true sense, does not and cannot inform these people that he requires their cooperation to become an ALJ. This obvious reality is ignored or denied by the Commission. It explains fully the findings of the Administrative Law Conference and Chairman Miller.[40]

VI

After an examiner has completed scoring or "profiling" the vouchers, the numerical score is added to the score obtained for Part A. If this combined score is less than 80 points, the candidate is told: [41]

"The Commission has determined your basic rating in this examination based upon a careful analysis of all the information filed with your application and the responses to our confidential inquiries. The evaluation of your qualifications showed that you met the minimum requirements in the examination. However, the score you attained was not high enough to meet the passing grade of 80 established by the Commission for the GS-15 [or the GS-16] grade level in this examination."

Although the Commission, at this point, refuses to permit the candidates to participate further in the examination process, a candidate receiving this letter has not concluded the examination. According to the Commission's instructions, the applicant's "final rating is to be determined on the basis of an applicant's quality of performance . . . [including] *his ability to write a decision and the result of his oral interview.*" (emphasis supplied).[42] In other words, candidates are failed before the examination is completed. Without the benefit of the balance of the examination, candidates are cut off from an opportunity to proceed by the Office of Administrative Law Judges. The commissioners apparently are unaware of this action. Former Civil Service Commission Chairman Macy either did not know how the Commission applied its procedure or the procedure is applied contrary to what he believed was done. In 1964, Chairman Macy stated ". . . applicants having basic eligibility were to be given an oral interview and were to be required to demonstrate their ability to write a decision." [43]

The candidates who have less than 80 points are told: ". . . you met the minimum requirements in the examination." What they are not told is that the Commission will not permit them to raise their score to 80 by allowing them to complete the examination and that the Commission itself is ignoring its own instructions. The Commission's action in this respect is clearly arbitrary and contrary to law. *Service* v. *Dulles,* 354 U.S. 363 (1957)

This letter, however, is not an isolated act; it is part of a whole pattern. Again mathematics will demonstrate that the error is built in: Under Part "A" an applicant earns a maximum of 60 points; under Part "B" he earns 40 points; the total earned is an aggregate of 100 points. How much will he earn for the written demonstration or the oral interview? Since the maximum score is 100, it is clear that for the last two parts of the examination he will only be downgraded, not upgraded!

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[40] See pp. 6 and 21 herein.
[41] CSC Form: CSC AJ-6.
[42] Rating schedule, p. 1.
[43] 50 Va. L.R. 896 (1964).

This is odd, to say the least. It clearly confirms that the Commission intends to subtract points for the last two parts, not add points.

Sending of this letter to an applicant who has less than 80 points, prior to the written demonstration and prior to the oral interview precludes a candidate from raising his score. The arbitrary judgment of the Commission in scoring Part "B" is now sealed; it becomes a fact and thereby dooms a candidate to failure before he has completed the examination. Yet the Commission's Office of Administrative Law Judges piously defends its actions and the Commission's Board of Appeals and Review has yet to reverse its first case because a candidate failed to get the requisite points because he could not finish the examination.

The oral interview and the written demonstration are available, as noted, only to those candidates that have obtained the passing grade in Parts "A" and "B". The possibility of gaining points on these parts of the examination are non-existent for the candidate who is denied the opportunity to take this portion of the examination.

The written demonstration has been criticized and not unjustly. Miller characterizes it as "demeaning."[44] There is merit to his view. The Commission's need for the written demonstration is questionable. It may be assumed that a candidate who has graduated from college and law school and has practiced for at least seven years, can write. In any event, there are more practical and less demeaning ways of testing an applicant's writing skills. Samples of what he has written, articles, briefs, etc. could be examined in lieu of the written demonstration. It is also questionable whether the Commission can really measure writing. Shortly after the Commission took over the ALJ selection program, one potential candidate was rejected because his decisions were biased as detected from his writing. That candidate had the distinction of having his opinion praised by the Supreme Court.[45]

The Commission permits applicants who failed to qualify for placement on the register to appeal the decision of the Office of Administrative Law Judges, but that appeal lacks substantive force. The Commission has no regulations governing the appeal to its Board of Appeals and Review, and what appeal is granted is limited to a review of the record.[46] No hearings are held. The applicant is furnished scant information covering the reasons he failed. The proceedings, to the extent they exist, are completely devoid of the most rudimentary elements of due process. *Thompson* v. *Gallagher*, 42 L.W. 2383 (1974). The applicant is not shown the vouchers nor is he told how they are scored. An applicant requesting this information is informed it is confidential. As a result, the applicant never knows what was said about him, nor does he have any idea how the Commission evaluated the vouchers. The Commission has never heeded criticism of its failure to open up the confidential inquiries.[47]

The right to cross-examine and the right to test the Commission's use of the information in its hands does not exist for these applicants. The character of the appeal is reminiscent of Star Chamber proceedings. It reflects no knowledge of recent court decisions. *William* v. *Zuckert*, 371, U.S. 531 (1963); *Green* v. *McElroy*, 360 U.S. 474 (1958). A candidate's rights hangs on a narrow thread to begin with, and error, inadvertently committed, may mean the death knell for the candidate's aspirations. In the past the Commission has been known to erroneously grade applications. When the Commission first established the hearing examiner program, it undertook to qualify the then incumbent hearing officers. After rating these sitting hearing officers, the Commission found that of the 217 hearing officers, 59 were not qualified. Attorneys were hired by the incumbents. Appeals were filed and a vigorous campaign to have that determination overturned was initiated. The agencies involved, notably NLRB and ICC, took up the case of the incumbents. A hearing was held, granted by the Commission because of the pressure asserted. The record was examined and the facts disclosed numerous errors on the part of the Commission. Ultimately, *all* of the incumbent hearing examiners proved they were qualified, or that the Commission's conclusion was based on error. Although the appeal rights accorded these incumbents were scant, they demonstrate, nevertheless, what can be done and that the Commission's record when fully exposed may contain errors.[48]

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[44] 25 Labor L.J. 11.

[45] *N.L.R.B.* v. *Pittsburgh Steamship Co.*, 337 U.S. 656 (1949).

[46] The Commission's Office of Administrative Law Judges deems an appeal timely any time, thus 5 CFR 300.104 (a)(2) with its requirement that appeals be filed within 15 days does not apply.

[47] One critic stated simply: ". . . the subpoena power rather than assurance of non-disclosure should be relied upon to elicit information from reluctant witnesses . . . " 59 Yale Law Rev. 475 (1950).

[48] 59 Yale Law Rev. 431 (1950).

This early test of the Commission's ALJ selection program required extraordinary effort, but it produced results. Today, however, the candidate attempting to challenge the Commission faces an impossible task. First, he has no knowledge as to the reasons he failed to score the requisite points. Second, the Commission refuses to furnish him its records. The reasons supporting the decision are not revealed and as a result never tested. BAR limits its review to procedural errors. Under these circumstances, an appeal is futile. Von Rinteln calls it "meaningless".[49] Today, as in the past, the "implication is strong that the Commission . . . [is] seeking to make it extremely difficult, it not impossible, for the appellants to get a full and fair review."[50] In essence, the appeal is one in name only and no meaningful review is intended. The right of appeal is so bare it is devoid of any due process.

VII

"If at first you don't succeed, try again". This folk wisdom, however, does not apply in the case of unsuccessful ALJ appellants. Announcement No. 318 states a candidate may re-file "no sooner than one year after the date on which he filed in this examination."[51] There is a strange inconsistency between the Announcement and the instructions to the examiners who will score this second application. That examiner is told that a second application is to be scored "keeping the old evaluation in mind."[52] The purpose these instructions serve is highly questionable. They certainly are not fair, their legality is doubtful. Should not a second application be evaluated on its own merits? A candidate, if he is given a second opportunity, is entitled to a fair and independent test, not to have his chances evaluated "keeping the old . . . in mind". The Commission would be more honest if it simply announced a candidate is entitled to but one submission and evaluation. At least applicants would realize they have only one chance, and one right to appeal. The number of cases that have gone to court filed by an unsuccessful candidate are perhaps only two. A partial explanation could be that unsuccessful candidates believe they will have an easier time (and less expensive) if they apply a second time. They are however, unaware of the Commission's instructions to its examiners. The gap between the rhetoric and the practice is a gross abuse of the public's faith in the expectation of fairness.

VIII

The selection of ALJs by the Civil Service Commission is oriented not to finding the ablest and brightest attorneys so much as it is in following its established procedures. The process is lacking in innovation; is confusing, is complex; and is rigid. It selects the least qualified. It does not measure skills as much as it classifies individuals. It offers an appeal, but has no regulations governing the appeal rights. It is administered contrary to its own instructions. It is above criticism and seemingly even beyond the Commissioners' control. Its examiners, not experienced lawyers, grade applicants based on points arbitrarily awarded. It is a system that never was acceptable and has yet to be improved so that its basic faults are corrected. About all that can be said for it is that it is administratively convenient.

The importance of ALJs to the administrative law process is far too important to permit their selection to continue in a business as usual manner. It is of critical importance that ALJs have the respect of the public and of the lawyers that appear before them. Whatever public image civil servants may create, ALJs require the respect of all. They must be endowed with ideals. They must be able to decide. They must remain independent. They must speak out in favor of what they believe is correct. They should not be afraid to arouse the animosity of their superiors lest the ". . . result is a great leveling of employees . . . (that) hear the beat of only one drum and march to it." *Arnett v. Kennedy,* ——— U.S. ———.

(Slip Opinion page 4, Douglas dissent, April 16, 1974). The present system tends not to foster selection of ALJs with these characteristics and, therefore, requires complete revision.

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[49] 35 I.C.C. Practitioners' Jrl. 15.

[50] 59 Yale Law Jrl. 461 (1950).

[51] Announcement No. 318, p. 16.

[52] Hearing Examiner Rating Schedule Supplement No. 6.

STATEMENT OF R. JACK POWELL, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

The Paralyzed Veterans of America (PVA), a veterans' service organization chartered by the U.S. Congress, represents veterans of the U.S. Armed Services who have incurred injuries or diseases of the spinal cord, whether Service-connected or nonservice-connected in origin. All of PVA's members are handicapped within the meaning of § 504 of the Rehabilitation Act as amended, and many members are current recipients of Title II Disability Insurance benefits administered under the Social Secruity Act.

The provisions of H.R. 5700, a bill to amend Title II of the Social Security Act, provides procedures for the review of continuing disability investigations. The impetus for this legislation comes from an increase in the number of disability reviews being undertaken by the States at the request of the Administration in an effort to remove unqualified beneficiaries and, hence, reduce costs. The bill represents a commendable effort by the Subcommittee to ease the arbitrary and reckless manner in which disability investigations are conducted presently. Nevertheless, we are concerned that the bill overlooks systemic problems within the disability insurance system. PVA believes that these internal difficulties may pose a far greater threat to the program's wellbeing than that posed by the undeserving beneficiaries. Therefore, our comments address specific items in H.R. 5700 and other problems within the Social Security System.

INCREASING THE ROLE OF THE RECONSIDERATION PROCESS

If Congress chooses to retain the reconsideration stage, then it must ensure that the process is meaningful. Provisions to improve the quality of this procedure should include face-to-face evidentiary hearings and lengthening the time to appeal an adverse decision from 60 days to at least six months. Neither change should preclude the introduction of evidence past the reconsideration stage. Maximum flexibility for the introduction of evidence should be maintained in view of the fact that many disability beneficiaries do not retain counsel until their case is heard before an Administrative Law Judge (ALJ). Moreover, important evidence may develop between the second and third level of adjudication.

UNIFORMITY OF DECISIONMAKING

Although PVA supports, in principle, uniformity of decisionmaking at all levels of adjudication, we are concerned with the provision that ALJs be bound by social security rulings and program operations manual systems. We prefer a provision which would subject the promulgation of rules for determining the disability process to public comment. Moreover, we encourage the Subcommittee to ensure that Social Security Administration (SSA) rulings be brought in line with Federal court decisionmaking. We are also concerned that own motion review of ALJ allowances undermines the ability of the ALJ to perform duties with impartiality, especially in view of the fact that the review process is limited to the review of allowances rather than disallowances.

Another serious procedural deficiency lies in the fact that State agencies are making determinations based on a standard of disability which is not required by the SSA and regulations. State agencies are judging all claimants by whether they "meet-or-equal" the Listing of Impairments which is required only for widows and children rather than utilizing the required standards which is different and less stringent.

IMPROVED MEDICAL EVIDENCE

Provisions in the bill should include the acquisition of quality medical evidence beyond the present inadequate system of medical examinations done by medical personnel under contract with the State agency. SSA should be required to obtain complete medical histories, physician reports, and other accompanying documentation prior to the termination of benefits.

Finally, the present law should be amended to include a requirement that medical improvement be shown before benefits are terminated. Unless SSA can demonstrate that the original finding was erroneous, it is clear that such a requirement is both logical and needed.

CAMPBELL & SCHMIDT,
Attorneys at Law,
Portland, Maine, March 15, 1982.

Re H.R. 5700.

Mr. JOHN J. SALMON,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C. 20515

DEAR MR. SALMON: I have learned that you are the appropriate person to write to concerning H.R. 5700 which involves some proposed changes in Social Security law. I note one of the proposed changes is to close the record in social security cases after a reconsideration. As an attorney who represents claimants in these cases, my experience is that attorneys are not normally hired until after the reconsideration level has been completed. Once in front of an Administrative Law Judge, an attorney usually has extensive new material to submit. It makes little sense to me to think of a hearing before an Administrative Law Judge where the record has already closed.

Thank you for your attention and cooperation.

Sincerely,

REMINGTON O. SCHMIDT.

STATEMENT OF SOCIAL SECURITY ADVOCATES

Section 7 of H.R. 5700, Disability Amendments of 1982, would amend current law by providing:

"Notwithstanding any other provision of law, the regulations of the Secretary, the Social Security Rulings (subject to such regulations), and the adjudicative standards of part 4 of the Program Operations Manual System (P.O.M.S.) published under the authority of the Commissioner of Social Security (subject to both such regulations and such rulings) shall govern determinations of whether individuals are under disabilities as defined in sections 216(i) and 223(d)."

The massive regulatory change proposed by H.R. 5700 would severely damage the due process hearing rights currently available to Social Security disability claimants. The destruction envisaged by H.R. 5700 would have the P.O.M.S.,[1] a manual written by bureaucrats for other bureaucrats, become binding on Administrative Law Judges' disability determinations. This would overtake current criteria for disability contained in the Code of Federal Regulations which were legally adopted after publication and comment.

Now, the P.O.M.S.' adjudicatory standards govern determinations made by State Disability Determination Services (and adopted by SSA District Offices) at the initial application and reconsideration levels. It is only after denial at the initial and reconsideration levels that a disability claimant is entitled to a face-to-face hearing before an Administrative Law Judge. There, the legally enacted standards for disability apply, as contained in the Code of Federal Regulations. There, a claimant is often represented by counsel and has additional evidence submitted in his favor. There, a claimant's case is often more fully developed, e.g., through use of a vocational expert or medical advisory testifying at the hearing. It is little wonder that if a claimant can survive the running of this bureaucratic gauntlet up to the hearing stage, s/he has a better than average chance to prevail on the merits of the case. Recent statistics show that while the rate of denial at the initial and reconsideration levels is increasing, the rate of favorable decisions by ALJ's (reversing those denials) is perforce also increasing, currently reaching 60 percent nationwide (see attached).

The proposed statute is apparently aimed at this variance in decisionmaking. Yet, the proposed solution ignores the real nature of the problem. The proposed solution blithely assumes that state agencies are right and Administrative Law Judges are wrong. The fact of the matter is that ALJ's usually have the advantages of an informed advocate, additional evidence (either garnered from sources overlooked by the state agency or solicited by counsel with a focus on the particular legal issues involved in the claimant's case), and, most importantly, the opportunity to actually observe the claimant face-to-face while discussing the merits of the case. Here, issues of credibility and subjective complaints enter the picture. An ALJ, for example, can evaluate the debilitating effects of pain, in light of the available medical documentation, in assessing a person's ability to function. (20 CFR §§ 404.1529, 416.929.) A state agency bureaucrat, under P.O.M.S., cannot.

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[1] Program Operations Manual System.

Some cases in point:

1. Sue D. is a 62 year old female applying for Supplemental Security Income. The consulting examiner for the state agency performed a psychiatric evaluation which resulted in a diagnosis of "organic brain syndrome such as Pick's or Alzheimer's disease." The consulting examiner stated that the "patient appears absolutely unable to function effectively in any environment. Her memory is too poor to respond to any types of regulations or rules." Yet, a DDS medical consultant who never saw, talked to, or examined the claimant found that she was not disabled! Sue's claim must now go before an Administrative Law Judge.

2. Betty C. was a 42 year old woman with a history of adult onset diabetes and amputation of the fifth metatarsal of the left foot. She carried four hundred and twenty five pounds on her five foot nine inch frame. The Social Security Administration criteria for impairments indicate that a person of that height weighing over two hundred ninety eight pounds ill be considered disabled if there is evidence of particular additional impairments. Despite the fact that Betty was one hundred and twenty seven pounds over the disability criteria, the state agency found that she was not disabled. Her claim was only granted when she appeared before an Administrative Law Judge, represented by counsel who submitted additional x-ray evidence of "degenerative changes of the knee joint."

3. Dorothy D. was a 23 year old woman with an above the knee amputation of her left leg after an accident involving an attempt to get on a moving train. The medical records before the state agency concerning this accident clearly contained references to "a white female who is retarded." Despite this clear evidence, the state agency did not follow through with any evaluation of the claimant's mental condition. After denial of disability by the state agency, the claimant's attorney at hearing presented evidence to the Administrative Law Judge that the claimant's I.Q. was below 70. Her claim was then ultimately granted.

4. Gene R. was a 43 year old male with a past work history of arduous physical labor. As a result of an on-the-job injury, Gene suffered a roto cuff tear to his left shoulder when he attempted to catch himself when falling from a scaffold. Under the Social Security Administration's criteria for impairments, even a complete amputation of Gene's left arm would not establish disability. However, in preparation for hearing, claimant's attorney solicited hospital records not obtained by the state agency and arranged for psychiatric and psychological consultations specifically aimed at the debilitating effects of pain and secondary depression from his injury. At the hearing, the Administrative Law Judge observed a man with a neck brace and an immobilizing device consisting of a corset to which the left arm was attached. The claimant was covered with sweat from the physical effort involved at attending this hearing, during which he broke down in uncontrollable tears at several points. Disability benefits based on the physical impairments plus two separate diagnoses of major depression, were ultimately granted by the Administrative Law Judge.

In fact, adoption of P.O.M.S. as the basis for ALJ adjudication will not establish uniformity, short of the actual establishment of a quota system for denials of disability. (Social Security Administration employees at lower levels have, indeed, admitted the existence of an informal quota system for denials of disability.) Administrative Law Judges have a variance in decision-making vis a vis the state agencies because by and large they are following their legal duty to conduct disability hearings "in an impartial manner." (Administrative Procedure Act, 5 U.S.C.S. § 556(b).) Rather than attacking the problem where the difficulties actually arise—at the state agency levels—H.R. 5700 is but a thinly veiled attempt to eliminate the present system of individualized disability determinations. In fact, H.R. 5700 is an attempt to change the judge into the holder of a rubber stamp for ratification of disability denials. Until we decide to abolish support for our disabled people, we should operate the system on a fair, individualized basis.

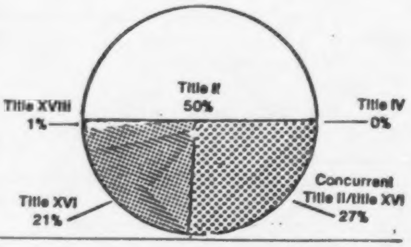
OHA FACT SHEET

FOR FISCAL YEAR 1980
SSA Pub. No. 70-039

Requests for Hearing
FY 1980

Receipts

	Number	Change from FY 1979
Title II		
DIB	120,491	↑ 13%
RSI	6,336	↑ 6%
Title XVI	53,256	↑ 8%
Concurrent title II/title XVI	68,979	↑ 14%
Title XVIII	2,800	↓ 28%
Title IV (B.L.)	161	↓ 12%
Total	252,023	↑ 11%

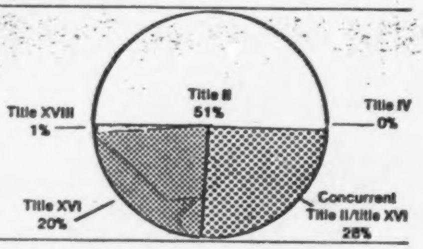


Dispositions

	Dismissed	Affirmed	Reversed	Total	Change from FY 1979
Title II					
DIB	8,499 (8%)	35,606 (32%)	66,235 (60%)	110,340	↑ 11%
RSI	898 (15%)	2,982 (50%)	2,066 (35%)	5,946	↑ 7%
Title XVI	6,467 (13%)	18,338 (36%)	26,034 (51%)	50,839	↑ 11%
Concurrent title II/title XVI	6,005 (10%)	21,944 (35%)	34,206 (55%)	62,155	↑ 12%
Title XVIII	670 (21%)	1,382 (44%)	1,108 (35%)	3,160	↓ 22%
Title IV (B.L.)	23 (14%)	72 (45%)	64 (40%)	159	↓ 36%
Total	22,562 (10%)	80,324 (35%)	129,713 (56%)	232,599	↑ 10%

Pending

	Number	Change from 09/30/79
Title II		
DIB	52,330	↑ 24%
RSI	3,044	↑ 15%
Title XVI	22,116	↑ 12%
Concurrent title II/title XVI	30,848	↑ 28%
Title XVIII	1,215	↓ 23%
Title IV (B.L.)	83	↑ 2%
Total	109,636	↑ 22%



Processing Times and Age of Pending

	September 1980	Change from September 1979
Mean Processing Time	160 days	↑ 9 days
Mean Age of Pending	109 days	↑ 7 days

Percentages may not add up to 100 due to rounding.

United Mental Health, Inc.,
Pittsburgh, Pa., March 26, 1982.

Hon. Dan Rostenkowski,
Longworth House Office Building,
Washington, D.C.

Dear Representative Rostenkowski: We are contacting you as Chairman of the Committee on Ways and Means regarding the effects of an accelerated review of persons receiving Disability Insurance (SSDI) and SSI.

United Mental Health, Inc. is a private, non-profit, United Way funded advocacy agency—the largest in southwestern Pennsylvania.

We are glad to know that Congress is attempting to alleviate the harm caused to the helpless and hopeless persons who have been arbitrarily and illegally dropped from SSDI and SSI rolls as an administrative attempt to save money.

We have some reservations regarding H.R. 5700 as the means by which the problem should be addressed:

Eliminating hearings of evidence by administrative law judges can only exacerbate the problem that exists because so many errors are being made at the level of the agency.

In order to provide the uniformity in decision making which is desirable, the law and the regulations should be the guide rather than the Program Operations Manual System (POMS) because of the inconsistencies existent in the POMS. This use only increases the probability of error.

The mentally disabled who are being eliminated will not be helped by increasing the burden placed on them by closing the records of evidence after reconsideration. They are not able now to represent themselves adequately and they are apt to seek legal help at this stage. This means that, when they get to a point at which they do look for some legal assistance, they must produce a complete and adequate record because the evidence which had been gathered is no longer available to them.

While the four-month adjustment period will help persons who are rightfully terminated, it will do nothing for the truly disabled person wrongfully terminated except to postpone the inevitable crisis.

Please look more carefully at this situation by scheduling oversight hearings before attempting to deal legislatively with the disability review process. So much depends on your understanding of the problems faced by the mentally disabled and others who are currently being denied the assistance they need to survive.

Sincerely,

John R. Echement, *President.*

Broomall, Pa., *March 13, 1982.*

Re Hearings on H.R. 5700.

John J. Salmon,
Chief Counsel,
U.S. House.

Dear Mr. Salmon: The devastation wrought by adverse changes in the Social Security Disability Benefits program should not be underestimated.

Already thousands of people have died or been broken as a direct result of changes. One who has been on disability for a reasonable length of time—one who depends on the benefits for his very existence, is ripped apart when the Benefits are taken away.

Disability Benefits are generally given to the disabled, aged, blind, handicapped and poor people. Those least able to defend against the ravages of living (or existing) without money. Most were once proud and strong; but are reduced to an existence which never existed in the Summer of their lives.

Personally, without S/S Disability Benefits, I, my wife (age 47); and, my 2 sons (ages 10 & 19) would starve or freeze to death. The contemplation of such consequences are enough to drive one mad.

I'm 49, a D.A.V. from the Korean Conflict and German occupation. I served my country well and honorably—now for some strange reason my country wants to turn their back on me and my family.

I believe it to be cruel, unusual, unjust and unfair.

Where is the quality of mercy—where is the humanity in a program that takes the very life out of its citizens?

In this Spring of 1982 after a cruel, harsh Winter the hope is only (for one on Social Security Disability) to make it to the next day.

Social Security gave me wings to fly.
Social Security took away the sky.

Relatives and people I know who are dependent on Social Security OA & S or Disability Insurance.

1. Me, My wife and 2 sons;
2. Mr. and Mrs. L. D. Warren I, Cincinnati, Ohio;
3. Mr. and Mrs. Harry Troth Jr, Westmont, N.J.;
4. Mrs. Frances Barnes, Collingswood, N.J.;
5. Mr. and Mrs. William Warren, Daytona Beach, Florida;
6. Mr. Lloyd P. Stilley, Shreveport, Louisiana;
7. Mr. Joey Rodriguez, Rosenberg, Texas;
8. Mrs. Anna Haines, Orlando, Florida; and
9. Miss Layne Jeffress, Chicago, Illinois.

Thank you.

Sincerely,

LEONARD D. WARREN II.

TEMPE, ARIZ., *March 28, 1982.*

JOHN J. SALMON,
Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, Washington, D.C.

DEAR MR. SALMON: I would respond to the Summary of the Disability Amendments of 1982, on which hearings were held March 16–17, 1982, and whose many components cannot be adequately addressed in a brief letter.

Without going through a line-by-line commentary, I would state an overall objection: the impact of HR 5700, while containing some commendable elements, would be to further jeopardize the concept of justice for disabled workers.

The problem seems to me to be the fact that you, in HR 5700, are starting from an incorrect assumption. You imply that the denial of 70% (more or less) of applicants for disability benefits is "good", and that when the Administrative Law Judges reverse the prior decisions in about half the cases coming to them the Judges are "bad". When you start with an incorrect assumption—as I believe this one is—you cannot but arrive at inadequate ways to address a problem which is inadequately addressed. Unless you are willing to consider the possbility that there are grievous errors in the system of disability decision-making, it is not possible to propose legislation to correct the problem.

The problem is not, in my view, with the Administrative Law Judges—they function now, as they should in a system which provides for checks and balances, as independent decision-makers, able to take into account various interrelated components in the disability claim which are ruled out in the instructions to the decision-makers at lower levels. The problem is with the decision-making at the state agency level, where the human being must be viewed as a reflection of medical notes, directing the disability examiner to see if the jigsaw puzzle has an exact configuration in one of thirteen different and distinct systems. The disability examiner, comparing the medical notes with the Listings, may find that the person claiming to be disabled does not quite meet the criteria set forth under the standard for arthritis, and does not quite meet the criteria under visual impairments, and does not quite meet the criteria under pulmonary function, and does not quite meet the criteria under depression. With the Program Operations Manual System (the POMS, which HR 5700 would make binding upon the Administrative Law Judges), the disability examiner is functioning in a properly bureaucratic manner in denying the person whose problems miss (by a smidgen, or perhaps more) the criteria in the Listings. commonsense would suggest that a person with five different health problems, even if the severity did not exactly match the Listings, may have more difficulties in maintaining an employment pattern than a person with only one health problem; commonsense has no place in the POMS, in the decision-making at the levels below that of the Administrative Law Judges.

There are, to be sure, some elements of H.R. 5700 which would help the disability claimant/recipient. But the misunderstanding which seems to inform H.R. 5700 appears to me to carry over in the addressing of the wrong end of the problem. If you are truly intent on improving the disability determination system, rather than assuming the judges are wrong because they provide the individualized justice our system of government has seemed to me to hold high all these years, you will:

Eliminate the Reconsideration stage, rather than close the evidentiary record at that point. Having the person be reviewed under the same unrealistic standard may keep certain people busy, but it does nothing to address the real problem, which is the theoretical and abstract decision-making instructed by the POMS and reinforced by the attitudes and instructions of the Social Security Administration.

Holding meaningful conversations with the staffs of congressional offices who know only too intimately the hardships wreaked upon disabled people by the system which is in operation. One of the marvels of our country has been its recognition of the individual, unique, unlike anyone else. By that recognition, we admit that the person is more than height, weight, age, education and laboratory tests—the person is, first of all and throughout, a person, not a composite of factors to be plugged into a machine as if a game of Bingo was at issue. Only as you and the members of the Committee understand that others—like yourselves—are individuals, are suffering extreme hardship and dehumanizing experiences in the process of applying for and receiving benefits, can you develop legislation which is more meaningful in addressing the real problem.

Recognize that the "state of the art" in medicine is constantly changing and that criteria set forth for disability determination in the Listings may be already outmoded, imprecise, or redundant for disability determinations. At this point, we do not have an objective finding in pain, for example. But you, if you have ever had bursitis or back spasms or phantom pain will not discount that experience simply because there is no lab test to confirm it. Pulmonary function tests, for example, that do not confirm disability for persons on oxygen four times a day by doctor's orders, for example, may be questioned as to whether the test is valid test of what it is supposed to test, or whether the doctor is inappropriately prescribing—the fact that the A.M.A. approves the Listings does not mean they are current and valid, in spite of that imprimatur.

Review denials of disability benefits, as well as allowances. You reveal your mindset and the orientation of agency instructors when you elect to review only those claims which are approved: what do think merits exclusion of denials from the review? Granted, it is much easier to deny (the jigsaw puzzle piece may have many more jagged edges), but our experience is that persons continued to be denied because the POMS are incorrectly applied, or the subtle (or not so subtle) pressure to deny exists.

For adequate development of legislation in this specialized area, you need more instruction than solely from the Social Security Administration and staff people themselves—you need the experience of experts and recipients on the receiving end of the decisions. We—I and others knowledgeable about recipient problems and the workings of the system—would be most willing to provide that information if you were truly willing to listen.

Sincerely,

RUTH WOOTTEN.

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